# Exploring self-compassion: An action research study with women who have been sexually abused as children. #wearenotalone

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**2019**

**ACKNOWLEDGEMENTS**

To my long-suffering family, who supported me throughout. Thank you.

To my Research Supervisor, Janet, and my Clinical Supervisor, Lynette, who offered good humour, patience and faith in me.

To the amazing, courageous women who were my co-researchers; thank you.

**ABSTRACT**

This research brought together eight women survivors of childhood sexual abuse (CSA) to explore together, as co-researchers, the concept of self-compassion. CSA is recognised to provoke feelings of intense shame (Negrao, Bonanno, Noll, Putman, & Trickett, 2005) leading to feelings of worthlessness and self-condemnation which impacts on psychological well-being (Coffey, Leitenberg, Henning, Turner & Bennett, 1996).

Action research was chosen - an approach of researching *with* rather than *on* people - with a focus on human flourishing and with the participants being the beneficiaries of the research (MacDonald, 2012). This was also an opportunity for avoiding the 'doer done-to' (Benjamin, 2004) dynamic, instead empowering women whose will has been subjugated in the past.

Eight women from a Rape and Sexual Agency met weekly over a period of five months to discuss and explore different psychological approaches and theories to see what was helpful in engaging with self-compassion, what were their barriers and, importantly - when a relational trauma is the cause - what was the impact of doing this in a group format?

Exploring this in a group was felt by all the women to be the most important element, as they experienced empathy and compassion for each other's critical and condemning self which, they recognised, mirrored their own experiences. The flattened hierarchy of action research with peers also fostered a developing sense of trust in each other's expressions of empathy and compassion and multiple therapeutic alliances.

In addition, psycho-education around the impact of trauma and developing an 'observing self' (Deikman, 1982) were helpful in bringing acceptance to the self, a pre-requisite before self-compassion could be applied.

The results were related to Neff's three components of self-compassion (Neff, 2008) - self-kindness, common humanity and mindfulness - and can be conceptualised as a movement from a deficit position of self-condemnation, isolation and experiential avoidance towards at least a neutral position from which to develop these three components.

It is argued that the content of theories and models introduced during the research were less important than the process of action research within a therapeutic group, and that this process has potential to be applied to different client groups.

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# CHAPTER 1: INTRODUCTION

## 1.1 Personal interest / reflexivity – why self-compassion?

My experience of working with sexual abuse started as a co-facilitator of the Sex Offender Treatment Programme (SOTP) in a Young Offenders Institute. Learning about their life stories gave me some insight to their own developmental trauma which led to such catastrophic transgression of relational boundaries. During the group sessions, hearing the men describe their actions and then reading victim statements describing their experiences motivated me to volunteer as a counsellor at an agency for victims of rape and sexual abuse. This was a mixture I think of professional curiosity of how to approach such a difficult area but also It felt somehow that I needed to put a face to the victims on paper and perhaps try to mitigate my own feelings of powerlessness which were involved when I was exposed to testimonies of historical violent abuse.

I expected the women to present with the more widely known elements of Post-traumatic Stress Disorder (PTSD) as per DSM-5 (American Psychiatric Association, 2013); perhaps intrusive memories of the event in the form of flashbacks (Criterion B3) or avoidant behaviour to avoid triggers (Criterion C2,). What I was not expecting, but found to be far more prevalent, especially in women who had been abused as children, was the persistent and exaggerated negative self-beliefs, as specified in Criterion D2, which resulted in often brutal self-recriminations and judgement. Again and again the women would tell me that they were “bad”, “not good enough” or that my kindness to them was wasted for “if you really knew me, you would know how evil I am”.

Often this defence mechanism was a barrier in the therapeutic relationship. I would get caught in a desire to alleviate distress but the response to my empathy and compassion was like a reflective shield. There was a part of them that desperately wanted help, the part that got them to the agency, but, at the same time, another part of them did not consider themselves worthy of that help. They often apologised for ‘wasting my time’ as other women were perceived as more deserving. The internal battle raged and it was, at times, difficult not to want to align myself with the part that wanted to be there against the more resistant part, rather than work with both. I struggled to understand what function the condemning part played to hold them in that position. This was the catalyst for wanting to understand more about the ‘detached condemning observer’ (Pines, 1990, p7), to explore what work was already being done in this area, wondering what could be done to alleviate the misery of the ever-present internal critical voice.

## 1.2 Introduction to Complex PTSD / Complex Psychological Trauma

The wide umbrella of PTSD as defined by DSM-5 (American Psychiatric Association, 2013) covers exposure to one or more traumatic events such as the threat of, or actual experience of, sexual violence, but is broad enough to include other traumas such as motor vehicle accidents, medical incidents and indirect experiences of trauma experienced by close relatives or friends. Despite evidence that prolonged interpersonal trauma from an early age impacts psychological functioning over and above PTSD symptomatology (van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005), alterations in self-perception and the impact on relationships with others are just one of the seven symptoms contained within criteria D which deals with alterations in cognitions and moods. With a total eight diagnostic criteria, PTSD has been described as one of the most complex diagnoses in the DSM, with over half a million symptom combinations (Brewin, Cloitre, Hyland, Shevlin, Maercker, Bryant, Humayun, Kagee, Rousseau, Somasundaram, Suzuki, Wessely, van Ommeren, Reed, 2017).

In contrast, the 11th revision of the World Health Organisation's (WHO) International Classification of Diseases (ICD-11) has introduced a new classification for Complex PTSD (CPTSD). It states that all diagnostic requirements for PTSD are met with the addition of the following three 'severe and persistent' symptoms:

'1) problems in affect regulation, 2) beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event, 3) difficulties in sustaining relationships and in feeling close to others.' (World Health Organisation, 2018).

This gives primacy to the problems with self-belief (criteria 2) and relationships with others (criteria 3) which I found to be so prevalent in my work with survivors of CSA. The symptoms of CPTSD outlined in ICD-11 are also more aligned with the conceptualisation of complex psychological trauma (Ford & Courtois, 2014). This is defined as resulting from exposure to severe stressors that:

1) are repetitive or prolonged

2) involve harm or abandonment by caregivers or other ostensibly responsible adults

3) occur at developmentally vulnerable times in the victim's life, such as early childhood or adolescence. Ford & Courtois (2014, p.13).

It is the timing of the trauma, 'during a developmentally vulnerable time' that provides the complexity which goes beyond the event itself and can impact fundamentally on the 'fragile,

immature, and newly emerging self' (Ford & Courtois, 2014, p.16). Cognition, the ability to self-regulate, to gain a sense of oneself as worthy and, importantly, the ability to see relationships as safe and nurturing are all at risk. Indeed, it has been proposed that 'all complex trauma is a trauma of intimacy' (Brown, 2014, p.167).

Shame has been described as a 'central feature' for women who have survived the experience of sexual abuse in their childhood (Negrao, Bonanno, Noll, Putman, & Trickett, 2005, p.351). The emotion of shame has been defined as 'the feeling we have when we evaluate our actions, feelings, or behaviours, and conclude that we have done wrong' (Lewis, 1992, p.2). As opposed to guilt, where the focus is on a specific failure, it is all-encompassing, a perception of the whole self as being defective. This 'inner language of failure, demoralisation and of painful comparisons' (Pines, 1990, p7), pervades all aspects of the individual's life resulting in a need 'to hide, to disappear, or even to die' (Lewis, 1990, p.2). This element of the self being both subject and object leads to what Pines richly describes as being one's own 'detached condemning observer under whose scrutiny the defect in the self, however small it may be, remains magnified' (Pines, 1990, p.7).

The phenomenological features of shame, as outlined by Lewis (1992), describe the breadth and depth of the burden as well as the challenge for therapists to support the healing process: the intense pain, anger, discomfort that is felt, the deep belief that one is inadequate, unworthy, no good and the never-ending self-persecution resulting from the fusion of subject and object. This damage that was done in relationship with another, supports a defence system of a desire to hide and to isolate oneself which can operate as a barrier to the therapeutic alliance and an opportunity to heal in relationship.

Such is the importance of early inter-subjective relationships in creating a secure base and as a vehicle to learn about affective states and emotional regulation, that the lack or loss of it has been described as the 'earliest and possibly most damaging psychological trauma' (van der Kolk, 1987, p.32). The experience of sexual abuse as a child from either a family member or an adult trusted to care for them in the parent's absence gives a further layer of complexity in the development of the self. The double bind of the 'good girl', the daytime self who compliantly maintains an illusion of normality and then becomes the night-time provider of sexual acts which can never be spoken of, and is therefore never semantically encoded, exists in a kind of dream-like state that is held as a secret (Davies & Frawley, 1994, p.32). The resulting confusion of experiencing the mutually incompatible loving, protecting other who is also a sexual perpetrator can result in dissociation as a defence to that which is intolerable. This can create different self-states acting independently from each other, generating flashbacks, dreams, inexplainable somatic experiences and anxiety (Lewis,

1992). It is this ‘core emotion’ of shame in women who are survivors of CSA (Talbot, 1996,p.11) which generates the powerful phenomenology of feeling unworthy, inadequate and ‘no good’, found to be associated with psychiatric symptomatology and disorders (Classen, Field, Atkinson, & Spiegel, 1998).

### 1.3 Research aims and questions

The aims of this research are to explore:

**The impact of exploring self-compassion in an action research group for women who have experienced sexual abuse as children.**

1. What approaches do they find helpful, if any, to help mitigate self-criticism, feelings of low self-worth and isolation associated with shame?

2. What are the barriers to developing self-compassion and can they be overcome?

3. Given that sexual abuse is an interpersonal trauma, what is the role of the relationship with the group in developing self-compassion?

# CHAPTER 2: LITERATURE REVIEW: SELF-COMPASSION AS AN ANTIDOTE TO INTERNALISED SHAME AND THE CONDEMNING SELF

## 2.1 Research evidence around CSA and shame

Research on sexual abuse has shown that high levels of shame and stigma attached to experiences of sexual abuse in childhood impacts on psychological well-being and recovery in adulthood (Coffey, Leitenberg, Henning, Turner & Bennett, 1996). Also, persistent shame is linked to higher incidents of post-traumatic stress symptoms which create a barrier to healing (Feiring & Taska, 2005). Shame has also been identified as mutually exclusive to qualities associated with hardiness: feelings of competence, the ability to have successful interpersonal relationships and the feeling of being in control of themselves, their bodies and the environment (Feinauer, Hilton & Callahan, 2003).

Survivors of CSA have been found to hold self-concepts such as being 'insignificant and undeserving' which highlights their critical evaluations of self and general lack of self-compassion (Saha, Chung Cheung & Thorne, 2011, p.101). Research focusing on self-identity showed 22 participants, all survivors of CSA, identified the theme of 'The Affected Self', characterised by shame, self-blame, boundary issues, aloneness and social stigma (Chouliara, Karatzias & Gullone, 2014, p.69). Recovery was aided by shifting the shame and re-attributing the blame to the perpetrator.

Lewis (1992) proposed that the wish to hide away is one of the four phenomenological features of shame and this provides an on-going challenge for both research and interventions. The challenge for research into the sequelae of sexual abuse and strategies to support healing is to access as many victims as possible. However, by the nature of their desire to hide their perceived inadequacies and failures from others (Lewis, 1992), victims experiencing high levels of shame, are hard to reach. For example, some insightful work has been done using constructivist grounded theory to explore women's narratives around their experiences of sexual abuse (Draucker, Martsolf, Ross, Cook, Stidham & Mweemba, 2009; Draucker, Martsolf, Roller, Knapik, Ross & Warner Stidham, 2011). Draucker et al's work explored how victims felt that they were able to move forward and heal after sexual abuse with the aim of developing a theoretical model of how the process of healing works.

If shame is a 'core emotion' of women who have been sexually abused as Talbot (1996, p.11) suggests, then it would be expected to emerge as a theme of the Draucker et al's research. This was not the case which I found initially to be puzzling. However, on reflection

it is perhaps inevitable that shame-prone victims of sexual violence would not volunteer for research which was advertised via fliers located in public areas such as libraries, grocery stores and coffee shops. Although the relatively high number of respondents (121) suggests a section of individuals who had experienced CSA did feel able to meet with a stranger and discuss their experiences, it is likely that survivors with high levels of shame were self-excluded from the study and this sampling bias would affect the results. This potential exclusion of the very participants I was interested in recruiting was important to hold in mind whilst reviewing the literature around sexual abuse, especially as we know that the wish to isolate has been linked to depression and anxiety (Pauley & McPherson, 2010).

### 2.2 Evidence-based practice for PTSD / complex post-traumatic stress disorders

Although I found much written on various interventions for trauma, the focus is generally on targeting the processing of memories or exposure therapy to regulate arousal. This focus of scholarly attention perhaps reflects a lack of interest in the intrapersonal and interpersonal impact of relational trauma which is surprising given the new classification of CPTSD in the ICD-11 (WHO, 2018, s.6B41). For example, Cognitive Processing Therapy (Resick & Schnickle, 1992) is a manualised programme focussing on cognitions. Forms of Exposure Therapy, such as EMDR (Shapiro, 2001), are included in NICE guidelines on the processing of traumatic experiences through repeated exposure. Even in the book 'Treating Complex Traumatic Stress Disorders' (Courtois & Ford, 2014), the interventions included, such as Cognitive Behaviour Therapy (CBT), Experiential and Emotion-focussed therapy and Sensorimotor psychotherapy look at cognition, emotions or bodily sensations but without specific focus on the challenges of self-perception and self condemnation.

With a paucity of specific attention to self-condemnation within both PTSD and complex trauma research, I looked to the relative new therapeutic area of employing the concept of compassion and self-compassion as a different way to address the shame led feelings of self-condemnation and worthlessness. An increasing interest in contemplative psychotherapy such as mindfulness and acceptance-based treatment has created a new focus for treatment on the *relationship* we have with our thoughts and the role that compassion has in this, rather than the *content*. Compassion has been defined as 'the wish that all sentient beings may be free from suffering' (Dali Lama, 2003, p.67) or 'basic kindness, with a deep awareness of the suffering of oneself and other living beings, coupled with the wish and effort to alleviate it' (Gilbert, 2009, p.xiii). Compassion defines the quality in which we are open, non-defensive and non-judgemental to the suffering of self and others (Gilbert, 2005). People who are self-compassionate are 'kind and understanding toward the self when failure, inadequacy, or misfortune are experienced' (Neff, 2008).

Research has shown a significant correlation between an increase in self-compassion and an increase in psychological well-being for the general population (e.g. Neff, Kirkpatrick & Rude, 2007; Odou & Brinker, 2015). The ability to show self-compassion has been positively correlated with reducing depressive symptoms such as rumination and decrease both cognitive and behavioural avoidance (Kreiger, Altenstein, Baettig, Doerig, & Holtforth, (2013). Other studies have shown self-compassion to raise self-esteem (Marshall, Parker, Ciarrochi, Sahdra, Jackson & Heaven, 2015) and increase healthy behaviours such as exercise, managing stress and quality sleeping habits (Sirois, Kitner & Hirsch, 2015). A meta-analysis of 20 samples from 14 studies showed higher levels of compassion associated with lower levels of mental health symptoms (MacBeth & Gumley, 2012). As is often the case, the majority of participants in these studies were self-selected female students but it suggests that the application of self-compassion might be helpful to the problem of self-criticism / self-condemnation for women who were survivors of CSA.

Studies of self-compassion have clearly demonstrated the potential benefits. However, this is a complex area and recent research has revealed that some people who experience high levels of self-criticism and feelings of unworthiness are extremely resistant to developing self-compassion to the extent of experiencing fearfulness of the concept (Pauley & McPherson, 2010; Gilbert, McEwan, Matos & Rivis, 2011). This fear of compassion has been linked to insecure attachment style and individual differences in the ability to self soothe (Gilbert, 2010; Pepping, Davis, O'Donovan & Pal, 2014) demonstrating the importance of early childhood experiences and the potential damage when sexual abuse occurs in this period, especially with a close and trusted adult.

A resistance to compassion is particularly relevant to survivors of CSA who experience shame and have corresponding feelings to hide away and isolate themselves. With this additional challenge held in mind, some useful research has been done on what has been found helpful in developing self-compassion in those who find the concept particularly difficult or even fearful. Surprisingly, given the beliefs about oneself in criteria 2 of the definition of Complex PTSD ICD-11 (World Health Organisation, 2018), no research has specifically looked at dealing with self-compassion in survivors of CSA. However, lessons from other shame prone clinical groups should be transferrable. For example, Gilbert and Procter (2006) found working with six patients in a day centre for people with high shame and self-criticism that psycho-education around the evolutionary functionality of emotions and the process of conditioning in early childhood helpful, as well as the validation and opportunity to share in a safe environment.

In another study, participants could identify that self-compassion would be helpful but, when asked, doubted their own abilities to develop the quality (Pauley & McPherson, 2010). The researchers remind clinicians that the therapeutic work starts from a negative stance rather than a neutral one and advise them to work first on the belief that it is possible to develop self-compassion, which may in itself be a lengthy process, before turning towards particular skill building.

## 2.3 Interventions with a compassion focus

### 2.3.1 Compassion-Focussed Therapy

One approach which puts compassion at the heart of therapeutic change is Compassion-Focussed Therapy (CFT), which incorporates neurobiology, attachment theory and evolutionary biology (Gilbert, 2014a). Gilbert's model suggests that self-compassion reduces the threat system and activates the self-soothe system involved in increases of oxytocin-opiate system, attachment and safety. Compassion-focused therapy uses psycho-education to normalise the habitual responses to perceived threat and the cultivation of compassionate capabilities though posture, tone of voice, imagery, compassionate letter writing and the practice of compassionate behaviour. A systematic review of 14 studies showed CFT was a helpful intervention to help cultivate self-compassion, especially for people high in self-criticism (Leaviss & Uttley, 2015) although no sexual trauma groups were included in the studies. Whilst there is insufficient evidence to date from a large enough trial to substantially state that CFT is more effective than other interventions such as CBT and other image based interventions, this is a promising start. Although CFT places emphasis on the affiliative nature of humans, the interventions focus on intrapsychic change through individual exercises albeit completed in a group format.

### 2.3.2 Mindfulness

Research has shown that both Mindfulness-Based Stress Reduction (MBSR) and Mindfulness-Based Cognitive Therapy (MBCT) courses can increase measurements of self-compassion although the courses in themselves do not explicitly have a focus on self-compassion (e.g. Neff & Germer, 2013; Birnie, Speca & Carlson, 2010; Shapiro, Brown & Biegel, 2007; Lee & Bang, 2010; Rimes & Wingrove, 2011). Based in the Buddhist tradition, the secularisation of mindfulness to the west has seen its growth not only for the general population but also, increasingly, into clinical areas in cognitive therapy (MBCT), Acceptance Commitment Therapy (ACT) (Hayes, Strosahl & Wilson, 1999) and Dialectical Behavioural Therapy (DBT) (Linehan, 1993). There is now a substantial body of research showing the efficacy of the approach for many different clinical needs including recurring depression

(Segal, Williams & Teasdale, 2013; Didonna, 2009) and trauma (Follette, Palm & Pearson, 2006).

Perhaps surprisingly, given the relative newness of mindfulness as a therapeutic intervention, research has been done in the specialist area of sexual trauma with promising results. An eight week MBSR course run with 27 adult survivors of CSA found significant reduction in PTSD symptoms and depressive symptoms, especially numbing and avoidance (Kimbrough, Magyari, Langenbery, Chesney & Berman, 2010). Impressively, the improvements were found to be long-lasting when 75% of participants were assessed after 2.5 years (Early, Chesney, Frye, Greene, Berman & Kimbrough, 2014). However, the experience of shame, self-criticism or compassion were not the focus of this research and these were not mentioned in either paper, possibly again due to the focus on PTSD symptoms rather than the problems arising from complex trauma. Also, the recruitment of participants was through a newspaper advertisement which may not have attracted survivors of CSA who were high in feelings of shame.

### 2.3.3 Mindful Self-Compassion

Mindful Self-Compassion, developed by Kristin Neff and Christopher Germer has been specifically designed to enhance self-compassion and is described by them as complementary to the standard mindfulness courses (Neff & Germer, 2013).

Neff (2008) sees self-compassion as comprised of three components with mindfulness as one component part. The second component Neff includes is self-kindness – the acceptance that life will have difficulties and that we will fail at times and the last component is common humanity – what Neff describes as softening the boundaries between self and other (Neff, 2008). This recognises the commonality of suffering and works as a counterpoint to the prevalent sense of isolation that is experienced with a lack of self-compassion (and with feelings of shame).

Results from an early study are promising. A pilot study, followed by a randomised control trial showed increases in self-compassion, mindfulness and life satisfaction and decreases in anxiety, depression, avoidance and stress (Neff & Germer, 2013). Interestingly, there were also small but significant increases in levels of self-compassion, happiness and mindfulness in the control group who, it transpired had started to actively read about self-compassion and tried to apply it to their lives. This is an emergent field and participants were recruited via internet announcements or referrals from therapists or yoga teachers, but it is nevertheless a promising start.

## 2.4 How to approach the research: the problem with 'interventions'.

Research has shown the problems that CSA survivors have with self-condemnation, the link to self-compassion and psychological well-being, and a complexity of a possible fear of compassion.

I initially completed a literature search for interventions regarding self-compassion such as Mindfulness, Mindful Self-Compassion and CFT, with the intention to choose what intervention might be appropriate to use with this client group. However I was aware that something was not sitting quite comfortably with me. My potential participants had survived an inter-relational trauma in which they had no agency, and I did not wish to re-enact that by pre-deciding on their behalf what might be helpful for them when I was outside of their experience. Any approach therefore which I had pre-decided might be helpful to participants with a history of CSA with high shame would be potentially disempowering, more symptom-led (a bringing to) than participant-led (a response to interest), affecting both their experience and outcomes. Therefore, whilst it was important to hold awareness of work in the field of self-compassion, I did not wish to assume the needs of the women whose voices have been silenced in the past.

In addition, the emotion of shame is a phenomenological experience which is around the internalised standards of others. As such, I wondered what the impact is of participants engaging with an intervention specifically designed to increase their levels of self-compassion. One could argue that these interventions carry with them an implicit message of what *should* be felt and expressed, providing an opportunity to demonstrate yet again self-condemnation if they were unable to do so. I wanted to avoid, as best I could, this dynamic whilst embracing what work has been done in this field. This topic is returned to in the discussion section (see 7.2).

## 2.5 Honouring whose voice is being heard – the feminist legacy

Completing my literature review made me reflect that a different approach was needed, one which seeks an egalitarian relationship with the women who are experts by experience and honours the feminist underpinnings of trauma treatment. Feminists first campaigned for trauma associated with domestic abuse to be included in DSM-III when PTSD first appeared in 1980. Feminists redefined rape as a violent crime, not a sexual act (Brownmiller, 1992). It was feminist therapists who argued that the clause of PTSD being 'outside the range of usual human experience' was inappropriate due to the commonality of interpersonal violence

experienced by women with the result that this clause was removed in DSM-IV (Brown, 1995).

Models for the treatment of trauma also often embody feminist values; behaviours following relational trauma such as dissociation and numbing of emotions are viewed not as deficits needing to be fixed, but inevitable neurobiological consequences of trauma and adaptive coping strategies (Herman, 1997). Therapeutic interventions hold the intention of empowering women to reclaim their authority regarding themselves, their lives and needs rather than noting the absence of symptoms (Brown, 2004). This resonated with me and my client work; one of them once proudly told me that she had worn a skirt for the first time in ten years as a statement of her independence the day she heard that the Crown Prosecution Service believed there was enough evidence to take her abuser to court.

Interestingly, although feminist values had already influenced the classification of sexual abuse and treatment approaches, the women in the group did not wish to label their research as feminist. As a piece of action research their perspective was respected (this is discussed more in section 3.1.2).

### 2.6 The importance of relationships

Advances in neuroscience have extended our understanding of Attachment Theory (Bowlby, 1988) evidencing the importance of attunement in early relationships to provide the building blocks of affect regulation (Schore, 2012). We know that attachment style, developed as a child, creates a relational pattern that is lifelong (Wallin, 2007) and that chronically abused people are more likely to develop an insecure or disorganised/dissociative attachment style (Kinsler, Courtois & Frankel, 2014). However, although it is acknowledged that the therapeutic relationship accounts for approximately 30% of improvement in psychotherapy clients, twice that estimated for technique and modality (Asay & Lambert, 1999), and that ‘the therapy relationship is itself the vehicle for change’ (Kinsler, Courtois & Frankel, 2014, p.187), it is rarely the focus of attention within trauma interventions, with symptom reduction playing a more prominent role. Where it has been a focus of the research, the strength of the therapeutic alliance was used as an explanatory factor in the success of participants to remain in treatment and acquire skills in affect regulation and reduce PTSD symptoms after exposure therapy (Cloitre, Stovall-McClough, Miranda & Chemtob, 2004). In addition, it is the relationship of client to therapist that is measured, which is but one dimension in the multi-relational dynamics of group work.

As discussed, the category of Complex PTSD in the ICD-11 recognises the negative self-concept and difficulties in relationships after a relational trauma. However, neither of these

areas, which involve problems of connectedness to oneself and others, seem to be given attention in their own right in the literature around interventions for complex trauma. Although this can be understood when there has been little focus in the past of these discreet symptoms in DSM/V and ICD-10, this also seems a strange oversight to me; increasing evidence from the relational, neurobiological perspective shows that change happens through implicit emotional connection with another, when someone feels a deep knowing of another. This opens up the potential for using non-verbal right-brain connection to provide unmet self-object needs such as mirroring and idealising, 'emotional self to emotional self' (DeYoung, 2015, p.73), which are so impoverished after the experience of CSA. Such is the integral role of relationship in addressing the needs of those who have suffered interpersonal trauma that, for me, this element had to be recognised and given due consideration in any phenomenological research. Within a group there might be a possibility to restore social bonds, explore commonality and perhaps move towards the feeling of a secure attachment, as well as the opportunity to co-create a new collective identity. There could also be the possibility to experience mirroring; the reciprocity of compassion, tolerance and love between the women in the group (Herman, 1997). This is beyond the therapeutic dyad, which holds an inescapable power differential, and places relationships with others centre place within a group which is researching problems with the relationship to oneself.

It was important to me to use a group format where peers could work together and have an opportunity to perhaps repair the relational damage done in sexual abuse. For this reason, a group, using action research as an approach was formed, to explore together the challenges and gains in engaging with self-compassion.

### 2.7 Contribution to the field

Although self-compassion is widely researched in different clinical populations (e.g. Neff, Kirkpatrick & Rude, 2007; Odou & Brinker, 2015; MacBeth & Gumley, 2012; Kreiger, Altenstein, Baettig, Doerig, & Holtforth, 2013), the application to women who experience high shame following sexual abuse as a child has received less attention. Specifically, it is hoped that the research could contribute in the following ways:

<u>Develop self-compassion within women survivors of CSA.</u>

The ability to overcome the condemning self-observer that is part of the phenomenon of shame could improve the psychological well-being and greatly enhance the daily lived experience of this client group. This is a notoriously difficult clinical need to work with, where feelings of self-contempt render, in their own eyes, the client unworthy of any help.

<u>Greater understanding of what works</u>

Communication of findings could assist other therapists in their clinical practice. Self-compassion is a relatively new therapeutic approach with some clients suffering a fear of self-compassion. An intervention that is both transtheoretical and transdiagnostic could create new ways of working with this and offer some much needed guidelines for overcoming the complex struggle to engage with treatment.

Impact on other therapeutic relationships

The process of developing the client's intra-psychic skills in a group such as reflective self-awareness, affect regulation, acceptance and self-compassion could potentially enhance the therapeutic gains in further individual therapy. This further therapy could allow for more personal exploration and depth in the space of a therapeutic dyad which cannot be explored within an action research group, thus providing more effective, focussed care, responding to individual client need.

Communication to other survivors of CSA

The action part of the research could involve communication from the co-researchers to other women survivors of CSA in the local agency which might help those women, in turn, to feel less isolated and understand their own lack of self-compassion. This harnesses the inherent need to be useful and of value to others.

# CHAPTER 3: METHODOLOGY AND PROCEDURES

## 3.1 Methodology

### 3.1.1 Ontology and epistemology – a rational for a qualitative approach

My epistemological position reflects my values of how people should be treated, which I espouse in my approach to clinical work as a psychotherapist and is at the core of the design and intention behind this research project.

I reject the deterministic philosophy behind the positivist and post-positivist approaches to research which look for cause and effect, as I do not believe that the complexity of the lived experience can be 'studied, identified and generalized' (Ponterotto, 2005, p.129). I therefore disagree that scientific rigour can be used in order to faithfully reproduce some objective reality which is considered to be 'out there' to be measured (Creswell, 2009, p.7).

Social Constructionism would therefore seem a suitable ally, where meaning is constructed from experience and mediated by the social context of being historically, culturally and linguistically situated (Willig, 2013). This alternative world view to the realism of positivism allows for multiple truths to coexist, which are socially constructed, created within historical, cultural and other social factors such as gender, race and economics. These are more than just lenses through which we view the world, they are active agents in how we construct our understanding of our individual realities (Campbell & Wasco, 2000). The meaning therefore we make of the world is co-constructed through relationships with others using shared symbols and signs which are recognised within a culture at a certain time (Grbich, 2007). This perspective is consistent with my increasing interest in feminist writings which have made me more aware of insidious messages to girls and women about how to conform in a patriarchal society (Gilligan, 2011). This approach also feels congruent with Counselling Psychology and its idiographic, relational view. My training at Metanoia focussed on the sense we individually make of the world as generated by our personal relationships, attachment schemas and transferences (Cozolino, 2012).

However, although I enjoy the intellectual challenge of a relativist ontology, where everything we consider real, including the material world, is a social construction (Gergen, 2015), I prefer the less esoteric participatory worldview of a subjective-objective ontology (Heron & Reason, 1997). This takes the position that there is a given cosmos but its objectivity is shaped by the knower. Congruent with social constructionism, this perspective also allows for multiple subjectivities which are intersubjectively created; that is through shared language, values, beliefs and experiential shared meanings. It acknowledges the use of narrative to define and describe experience, creating a conceptualized self through the stories we tell ourselves of how we conceive of ourselves in the world (Hayes & Smith,

2005). Our reality therefore is constructed through language and within a social context (Willig, 2013) and we 'fashion and shape our lives' through it (Pickard, 2015, p.1).

A participatory worldview adds a broadening to the social constructionist focus on language with the use of an extended epistemology (Heron & Reason, 2008) and this, I feel, captures more fully the subjective experience of the world. Language is included within presentational knowledge as are other symbolic expressions such as music and graphics. Propositional knowledge captures theoretical models and theories but holds them as relativist, mediated accounts. Practical knowledge, in the form of skills are incorporated and, within an action research project, are utilised in the action part. Lastly, experiential knowledge gives room for the experience of presence in relation to other things, people or places (Heron & Reason, 2008).

The qualitative honouring of experiential knowledge is an essential element to include; the felt sense of being in the world, from empathic resonance and emotional attunement to a sense of isolation and unworthiness, and all that lies between. For it is experiential knowing that shows up in the therapy room which includes the felt sense of shame and self-condemnation that was particularly present for survivors of sexual abuse. A qualitative methodology which holds this as datum was essential for me to explore the constructs of shame and compassion within a subjective-objective ontology. Through the use of critical subjectivity we can endeavour to validate and accept the primary subjective experience, viewing it through a lens of propositional knowledge whilst always holding this lightly as a possible way of understanding ourselves better, rather than a truth of how things are.

Within this position my own values and lived experience are embraced within the research; the personal always present in the professional. By dismissing the ontological position of an objective reality and exploring how our realities are constructed and interpreted (Campbell & Wasco, 2000), my own subjectivity is inherent in the process. The choice of research topic, the methodological approach chosen and indeed, my taking of a Doctorate in Counselling Psychology, all being the product of my life experience so far; my values, beliefs, interests and social identity. This has shaped the research and the research in turn has had an impact on me which was recorded and reflected upon throughout the process.

In rejecting the positivist stance of the researcher remaining objective to obtain scientific neutrality, I was interested in avoiding, as best I could, a divide between the one who examines and the examined where the participant's contribution and usefulness is constrained within a submitted academic document. Instead, the intention from the beginning was to sit alongside the women who would co-research the topic with me, empowering them to find their own meaning in the process of the work. Action research was

therefore chosen as an approach which both reflects this intention and holds the primary purpose of action in the service of human flourishing (Heron & Reason, 1997).

### 3.1.2 Action research

Action research, an umbrella term encompassing a 'family' of approaches, has been described as less a methodology than an 'orientation to inquiry' (Reason & Bradbury, 2008, p.1) with transformation at its core and an agenda of empowerment (Nelson & Prilleltensky, 2010). Research is done *with* and *for* people rather than *on* people - presenting an opportunity for education, personal development and social action (Reason, 1988). This orientation to both theory and action, using knowledge to improve practice makes action research an attractive approach for counselling psychology (contribution to the field 2). Different approaches such as Participatory Action Research, Co-operative Inquiry, Action Inquiry and Feminist Participatory Inquiry have different origins (Herr & Anderson, 2015) but over the last two decades people have worked creatively with these approaches and they are recognisable more from their commonality of characteristics around 'liberating the human body, mind and spirit in the search for a better, freer world', than their differences (Reason & Bradbury, 2008, p.5). Indeed, Reason and Bradbury (2008, p.7) encourage us to 'be creative' in how action research is used as there is 'no right way' of doing it.

Many forms of action research share a critique of orthodox science which places the researcher firmly outside and separate from the subject of research (Reason, 1994). The focus of action research is on human flourishing with the participants being the beneficiaries of the research (MacDonald, 2012). Many approaches share a relativist ontology; that we, both as individuals and as a collective, create our own meaning which is 'simultaneously created by us and manifested through us (Reason & Rowan, 1981, p.98). This is completely congruent with my values and style as an integrative therapist where I am interested in an I-Thou subject-relations of the here-and-now existential encounter between individuals (Clarkson, 2003).

The transformative nature of action research has the potential to give voice to women who have been silenced in the past in a truly co-operative, empowering way. Instead of a hierarchical relationship with me bringing something to 'fix' them in a dynamic of doer done-to (Benjamin, 2004), it is an approach which enables them to make choices about the research in a relational framework, with *the process itself* being liberating. As Maguire writes, 'the process of engaging in collective investigation, education and action is as potentially empowering as any of the actual 'knowledge' produced' (Maguire, 1996, p.109). Action research also embraces four different types of knowing; it is fundamentally experiential, with knowing coming from 'felt participation in the presence of what is there' (Heron & Reason,

1997, p.3) but also embraces presentational knowing, propositional knowing and practical knowing, giving flexibility to what can be considered as data in the research.

This project could also be considered feminist in its approach according to the four themes which characterise feminist research: expanded methodologies, connecting women together, reducing hierarchies between researcher and participants and recognising emotionality of women's lives (Campbell & Wasco, 2000). However, I was reluctant to identify this research as feminist 'per se' as, to honour the collaborative ethos of action research, I did not feel that it was appropriate to have pre-determined the philosophical perspective on behalf of the co-researchers. A basic premise of the feminist perspective is that we live in a culture which is patriarchal, prejudiced and discriminatory, but I felt that it was not my place to make this assumptive worldview for other women. If this research had been positioned as feminist its focus would have been more on how the participants were disempowered by their gender alone. It could also create a different power structure with me as enlightener rather than the flattened hierarchy of action research. I was also conscious that I should not presuppose the gender of their perpetrators nor do anything to potentially damage any relationships which currently brought comfort. This was validated during the research when I asked the co-researchers half way through the research if they would be interested in the Director of the Agency speaking to them about feminism. This was universally rejected as an idea, with one woman saying that she was frightened it would turn her against her husband, who was her main source of support. However, although there was not an explicit focus of attention in the group on positioning this research as feminist, I could not ignore the fact that the research group were all women who had grown up in a culture which conditions both women's and men's behaviour to conform to gender expectations. I would therefore position this research as situated within a context of feminist values to empower women ('soft' feminism rather than 'hard' feminism to align with the political narrative of the day).

### 3.1.3 Principles of an Action Research project

Although there is an egalitarian orientation in any action research project, this does not preclude different individuals bringing along their knowledge and skill sets. My participants didn't need to hold psychological knowledge or I their experiences of sexual abuse in order for us to work collaboratively together. For this project then, in the spirit of transparency, I was able to bring my knowledge of psychology, mindfulness (as a mindfulness teacher) and my clinical experience of trauma from working at the agency for several years. However, the choice of exploring any of these perspectives further, was the participants, based on their responses to the concepts presented i.e. the content of the sessions and the process, discussed and integrated as part of the research spiral. This was the essence of the project; that action research as an approach could potentially offer the opportunity for empowerment

within the process itself. This could come both from the content of the sessions but also from the spirit of cooperation, the validation that comes from feeling that they were a part of something and that their views were valued; 'change does not happen at the end, it happens throughout' (Wadsworth, 1998, p.9). This way of working is completely congruent with theory of trauma recovery whereby the empowerment of the survivor is the first step (Herman, 1997). To ensure that safety issues were paramount, I planned a session on coping strategies and a psycho-education session on trauma early on so that the women could learn about their responses to triggers. After that, the women chose their own session topics. Data was captured throughout; this was an evolving methodology and the writing up of my dissertation captures the evolution of the process (Herr & Anderson, 2015).

What I also found appealing about action research is the recognition that myself as the researcher cannot be separate from the research; I brought my own values, experiences and ways of seeing the world to the task. This is entirely congruent with the Metanoia Doctoral Programme philosophy of bringing the personal into the professional and avoiding fragmentation (DCPsych Student Programme Handbook 2015/2016) and supports the post-structuralist position that pure objectivity is misleading and unobtainable (Gray, Fitch, Davis, & Phillips, 2000). The experience of using action research, of its challenges and tensions is discussed more fully in the Discussion, Chapter 7.

In summary, this research is about the challenge faced by women, who have been sexually abused as children, of engaging with self-compassion. Qualitative research, which involves the researcher to respectfully sit alongside the participant with empathic attunement rather than the more doer, done-to (Benjamin, 2004) relationship inherent in manualised programmes, was chosen as appropriate for research with women who have been objectified in the past. It was congruent with my feminist values for the participants to have their voices heard. If I had already pre-selected the subject matter, an intervention, choice of inquiry method and put a limit on creative thinking, then any participants would still be 'subjects' who are other directed (by me) and I would be removing the self-determination element which characterises them as subjective beings (Reason, 1988). It was for this reason that I decided to use action research where I could sit alongside the women as experts by experience in an approach which moves from 'subjects to subjectivities' (Tolman & Brydon-Miller, 2001).

### 3.1.4 Dissemination and the action part

To me, action can be seen at different levels. On an individual level, action is inherent within the process of the research cycle, with its possibility for personal change (Brydon-Miller,

Greenwood & Maguire, 2003). As Maguire states 'all the theorising in the world, feminist or otherwise, is of little use without the doing' (Brydon-Miller, Greenwood, Maguire, 2003, p.15). I saw the design of the research, which seeks the inclusion of women who have been silenced in the past, in itself an action of social justice, and a potential to build theory from experience rather than apply theory to practice. Indeed, it is a mistake to focus only on action following the research as it is the action *of the project itself* that is researched, changed, and re-researched within the process (Wadsworth, 1998) and the process, rather than the content, was to prove the most potent part for the co-researchers.

Prior to beginning the research, I used my contacts through the Agency and my position in the Management Committee to be able to position the research and to assess the agency's motivation / interest in supporting any potential action points suggested by the women – if any action they proposed was blocked by a rigid or disinterested organisation this would not have been a viable project.

## 3.2 Research design

### 3.2.1 Researcher-initiated study in response to client need

As this research is in part fulfilment of a qualification, the research titles and sub-questions were already defined in order for it to pass proposal stage but were broad enough to allow for participants input into the actual content of the sessions. The tensions of power within a co-researcher structure but with a single authored output is further explored in section 7.8.1.

Within the family of action research approaches, this project used a clinical inquiry research (CIR) approach (Schein, 2008). In this approach, the knowledge produced is a by-product of helping clients develop greater insight into a problem ('contribution to the field' number 1) whilst also a deepening understanding of an issue could also be helpful for other clinicians ('contribution to the field' number 2). Although my project was not directly service user initiated, the research motivation was a product of observing a client need. Due to the very nature of the problem with feelings of unworthiness and isolation, service users were unlikely to proactively seek assistance specifically for these areas and did not at the time have a way of doing this via group work. The approach of CIR uses both high levels of involvement from the clients and also from the researcher with a shared responsibility for exploring the subject matter. My role was one of facilitation; the group initiated the topics for discussion, elected a chairperson for each session and suggested in the first session to reflect upon a specific journal question after every session. In my role, I kept focus on the topic being discussed and brought psychological understanding to their experiences. All models / theories were held lightly for the women to see if they resonated with their experience or not. The women

decided at the end of each session whether to continue discussing that topic or to move on. Action research emphasises collaborative working together, where it is recognised that different skills and experiences are joined together to make sense of a problem. Therefore, my co-researchers and I shared our knowledge to create new understanding in a spirit of co-learning (Herr & Anderson, 2015).

The research, of course, was situated within the context of time and culture. The media coverage and public outcry against childhood sexual predators such as Jimmy Saville and Rolf Harris helped to destigmatise CSA and the #metoo movement made it more commonplace to speak about victim experiences. My choice of action research as a methodology was probably subconsciously influenced by an increasing zeitgeist of co-constructed groups such as patient forums and of my previously working with Circles UK, where community volunteers work with offenders to reduce sexual offending. In addition, my own understanding of sexual trauma and self-compassion was informed by current Western psychological model and theories (see 3.5.6).

Positionality was given careful consideration as it underpins epistemology, methodology and ethics. I am a white, educated, liberal, middle aged, a feminist, probably classified as middle class, British woman, wife and mother, writing this in 2018/9 and all of these things provide context and position me within the research. My position was as an 'outsider in collaboration with insiders' (Herr & Anderson, 2015, p.49). I set a research agenda to complete a piece of written work to fulfil the requirements of academic criteria but positionality is a multi-layered concept; I was an 'insider' by gender, an 'outsider' by experience of abuse and the many other ways of accessing sameness or differences: education, ethnicity, social positioning, attachment style was, at the time, unknown. I also recognise that I held multiple roles within the process: researcher, facilitator, trustee of the agency, participator (to a certain extent) and that this had potential to create a tension between my needs and understanding and honouring their needs (see section 7.8.1).

### 3.2.2 Working collaboratively – recruitment of co-researchers.

Access to potential participants was through an Agency for rape and sexual abuse survivors where I had been working for approximately five years. The collaborative design of the research was completely congruent with the ethos of the Agency whose way of working prioritises supporting women in gaining control of their lives and of empowering women survivors to make decisions for themselves when dealing with the aftermath of sexual violence.

I received wholehearted support and encouragement from the Agency management. An email was drafted to all women who might be potentially interested in being co-researchers,

with a flier attached (Appendix 1). A copy was sent to staff and volunteer counsellors one week before its planned sending to make them aware of the contact with their service users and to give them the time to contact me should they have questions or concerns (none were raised although a couple called me to find out more and to express interest). The email was then sent by the Office Manager to approximately 150 women known to the agency (waiting list 40/50, in counselling at the agency 38, ISVA case load 50/60, Befriending 2, BAME 4, Women's Group 8).

### 3.3 Trustworthiness and coherence.

The quality of this research could be viewed through different lenses. Much has been written around quality in action research. Some of this focusses on elements such as the challenging of social systems (catalytic validity) or the extent of collaboration with all parties (democratic validity) (Herr & Anderson, 2015) which was not as relevant to the clinical inquiry research approach taken here. Some action researchers are uncomfortable with the term validity with its positivist leanings and prefer the expression trustworthiness, or coherence (Herr & Anderson, 2015). In this project, I had to single author the written outcome and my task was to ensure that my interpretations were credible to the women in the group. This was consistent to credibility checks of the data and analysis required for good qualitative research (Elliot, Fischer & Rennie, 1999). Every effort was made to ensure that there was coherence in my interpretations from gaining consent to record the discussions through to the invitation for the co-researchers to check over transcripts, summary notes and other relevant forms of data analysis, (e.g. the identification and naming of themes) with complete transparency throughout. All co-researchers were invited to independently analyse the transcripts for codes / themes which helped check any biases or oversights in my work and one woman did this for Phase One (her own work commitments prevented this for the other phases). Three co-researchers met separately with me to read my analysis of the findings. It was not the intention of this research to lay claims to internal validity truths about developing self-compassion or external validity truths around how generalisable the findings were to a wider population, but to explore this client led clinical problem together. This falls within Schein's definition of 'high researcher and high client involvement' (Schein, 2008, p.273) whereby I was responding as clinician / consultant / researcher to a client need and together we actively worked towards improving the helping process.

In each session a paraphrased version of the seven quality points of action research (adjusted to be more accessible) were on display (Bradbury, 2014: see Appendix 2) and these were actively challenged and referred to , ensuring that they were part of the process.

For example, in order for everyone to be involved (point 2), the quieter members were given space to contribute.

## 3.4 Data collection and analysis method – thematic analysis.

### 3.4.1 What else was considered and why rejected.

I initially considered using Interpretive Phenomenological Analysis (IPA). However, although the ontological and epistemological framework of IPA (critical realism and contextualism) was not incongruent with my own, I did not like the idea of subscribing to a package of presumptions: a recommended sampling strategy (small number, homogenous) and of using one-to-one interviews for data collection (Smith, Flowers & Larkin, 2009). I could completely understand the benefits of one-to-one interviews in giving the opportunity for 'in-depth and personal discussion' (Smith, Flowers & Larkin, 2009, p.57) as being conducive to understanding individual phenomenology. However, my intention in this piece of research was for the group of women to explore the concept of self-compassion together. Therefore, I wanted to have more flexibility of data collection to include group discussions, and even other forms of experiential expression such as poetry writing or graphics, if that was what the women wanted.

I found that thematic analysis (TA) gave me the flexibility that I was looking for. As it is considered a method of collecting and analysing data, it gave me the theoretical freedom to choose action research as my methodology – itself with the hallmark of flexibility (Psych.auckland.ac.nz, 2017). I also liked the fact that TA could look for patterns of collective or shared meanings and experiences (Braun & Clarke, 2012) which I thought particularly relevant for group work as opposed to the more ideographic focus of IPA.

### 3.4.2 Data Collection

The approach of action research meant that there was engagement with the data throughout the research; each week the session was transcribed, themes identified and summaries made. As a group, we could use a wide range of corpus data, from interviews to group discussions and collages, for example, our created Tree of Life (Appendix 12) which collaboratively demonstrated our shared strengths, connections and goals. Our data set reflected the research questions: helpful interventions to help develop self-compassion, barriers to self-compassion and the experience of exploring this in a group. The use of flipcharts at every session, with co-researchers sometimes writing them or instructing me what to write, helped to capture everyone's contributions and helped produce co-constructed summaries of our work together. This helped us to keep close to the group's insider meaning-making rather than my outsider interpretation.

Other data came from a research journal for the co-researcher's reflections which was suggested at the first session by one of the co-researchers. Every session ended with an agreement of a specific question to think about over the coming week. Some women chose to write in their journal and read it out or use it as an aide memoir the following week during discussion. Some wrote down the question and then emailed their thoughts. This was their personal reflection space. It was made clear at the beginning of the research that the journals would not be collected in at the end and the reflections captured in them would only be used if brought to the group. My own research journal was used to capture my own personal reflections and notes.

### 3.4.3 Analysis of data

Analysis of the sessions was viewed through the lens of constructivist-interpretivist whereby the women constructed their own realities of how they conceived themselves and others within the context of their lived experiences which were themselves gendered, culturally and historically situated. A different methodology, for example narrative analysis, would have been interesting to show how their stories were constructed, contested or accepted by and for each other (Andrews, Squire & Tamboukou, 2013). However, for me, this would have excluded some of the broader elements of their experience, for example the physiological impact of trauma which is a well-researched area of trauma.

Each session was transcribed orthographically including hesitations, pauses, false starts and other utterances such as 'hmm' or 'umm'. Half of two sessions were transcribed by an Assistant Psychologist at my work (with a confidentiality agreement signed and consent obtained from the co-researchers), the rest by myself. Voice recognition software was used and informal notes / codes were made at the side of each transcript. These were a mixture of the more descriptive, semantic and latent levels of meaning where some interpretation of their narrative based on my knowledge of trauma theory or other psychological constructs was used. For example, a comment from one woman that she 'couldn't speak' was interpreted by me as feeling 'touched by another group member – connected' which went beyond her actual words to the tone of voice and feel of the exchange between them. I used colour and highlighting to help me keep track of repeated patterns of meaning. The flow of conversation and the human responses to each other's suffering and joys organically captured the 'depth' of issues which sometimes were not concerned with prevalence but were captured because they were experienced as important. I used my judgement to decide what was transcribed and coded; at times there was general chit-chat about last night's TV or traffic on the way to the session and I made the choice point not to transcribe this as it

was not directly relevant to the research questions. Not all data was used, for example, the Tree of Life (Appendix 12) was declared an enjoyable group task but added little to the research questions.

The annotated transcript, plus a summary of the previous session were placed on a table for the co-researchers to read and comment on. This gave the opportunity for transparency of my interpretative notes of contributions both consciously and perhaps unconsciously made throughout the process. Some women choose not to re-read the full transcripts of what had been discussed in the sessions, remarking that it would take them too long or that they did not wish to revisit what had been discussed. However, others read it with interest and confirmed their agreement to what was captured. On a couple of occasions, women corrected my assumptions and the transcripts were duly amended.

Inherent in the design of action research, analysis was conducted throughout, in and with the group.

Being with the group, relistening and transcribing, identifying codes (some of which later became themes) and summarising each weekly session before the next one gave an opportunity to immerse myself in the data, but it was detail focussed and difficult to see at the time the emerging dynamics and 'story' of the group. It was as though I could see the small parts of a tapestry as it was being worked on but not the wider perspective of the whole picture in focus until the end.

After the weekly sessions had ended, recordings of all sessions were re-listened to and transcripts re-read several times. Again, I looked anew at the transcripts to identify themes with supporting quotes as, by this time, five months had passed since the early sessions. Comparisons to the original identified codes were made and consolidated (see Appendix 3 for an example). I then created a table for each of the three research questions and put the weekly themes into it (i.e. from across the whole data set). This helped me to identify the developing 'story' of the research.

To avoid feeling overwhelmed with data, I completed this work one phase at a time as, when I read back over the transcripts the group sessions seemed to naturally fall into three phases.

'Phase One' consisted of the first five weeks and was a period of settling in to the group, establishing what we wanted to explore together and ended in session / week five, with the output of our first draft framework around the development of self-compassion.

'Phase Two' covered sessions six to ten, a period of group cohesiveness in which the exploration of boundaries and trust went deeper.

‘Phase 3’ was one of consolidation and action planning. A Day of Compassion was held in week eleven and an ‘Endings’ session in week thirteen. I also included ‘session fourteen’ which was held two months after the last weekly sessions as it gave an opportunity for reflection and consolidation of the whole process.

This more in-depth analysis gave the opportunity for a more latent approach (Braun & Clarke, 2006), as I was able to reflect on not just what was semantically presented but what perhaps the function of the narrative was or what psychological ideas and theories lay behind that. I was very aware at this stage of the research that the power dynamics changed and it felt that I was researching on rather than with for the first time (see section 7.8.1). The flow of discussion in our sessions together did not fit neatly into boxes so the categorisation of the co-researcher’s phenomenology for writing up seemed, at times, clumsy and artificial. For example, a discussion around coping strategies would often be around the inherent problems of those strategies (for example, experiential avoidance). Within the word count parameters, some heartfelt and interesting themes were not taken forward as they did not directly fit the research question around self-compassion. A very moving discussion, for example, on the co-researcher’s relationships with their mothers (mostly centred around whether they believed / did not believe disclosures of sexual abuse) was not developed further but could have been served well as an independent research topic.

Congruent with Action Research, the annotated transcripts were taken back to the women each week to check my assumptions. They were also asked to play a more active role in the analysis, should they wish to. Analysis was helped by one co-researcher, Sally, volunteering to also read through the transcripts and identify themes which provided some trustworthiness of my interpretation (Herr & Anderson, 2015). It also helped to circumnavigate the double hermeneutic of me holding the responsibility of trying to make sense of another’s subjectivity. Unfortunately, a change in her job meant that this was only done for Phase One.

The process of involving a co-researcher in analysis generated a mixture of tensions for me. I was, on the one hand, grateful for the opportunity to share the work load and better ensure the trustworthiness of the results but I found myself slightly uncomfortable about sharing the full transcripts in case they were triggering. Although, of course, she had been present in all of the meetings, I had found myself personally impacted more by the material when it was brought in to my home environment. From our conversation when we did meet I think that I was being overly cautious and in fact, she stated that she had found the process “fascinating”. It was reassuring to find that her themes matched mine with some additional insight to my role in the group to which I was blind (see 4.3.1).

As this was after the group sessions had finished, I was also aware that I was concerned about this co-researcher's expectations of a different type relationship with me and her possible need to fulfil a different, more empowered position from the other group members. This elicited some difficult feelings for me; I wanted input from a co-researcher to help ensure the trustworthiness of the research but I also did not wish to take advantage of someone who was perhaps using this as a way to foster a closeness to me and be the 'favourite' sibling. All I could do was be warm, professional and keep boundaries, which I did.

Once complete, care and consideration was given how best to disseminate my interpretations. I was keen to return to the group with my final analysis but it was hard to find a mutually convenient time and five women did not express an interest in this part of the research. I met with the three women who expressed an interest individually. There were also ethical considerations around the sharing of the analysis. I felt some anxiety around the change of positionality from sitting 'alongside' to sharing my psychologically informed analysis of their input in the sessions but all were interested in the summary. I made a choice point not to leave any paperwork with them to avoid, as best I could, reinterpretation and rumination.

After the themes from this research had been identified and analysed I was interested to see how our independent findings complemented or contrasted with established theory on compassion which would inform the Discussion part of the write up. A deductive approach was therefore taken at this stage and the inductively produced themes identified in our research were applied to Neff's three components of self-compassion (see Appendix 4) and section 7.6. This part of the analysis was slow and in depth. I booked a cottage in Cornwall for a writing retreat in December 2017 to immerse myself in the data and challenge myself in the relevance of my results to other work on compassion. I also used meditation to 'sit with' the themes in an endeavour to resonate with the experiences of the women and better understand their phenomenology. Slowly, the picture emerged of the movement towards Neff's components from the deficit position of trauma (see 7.5).

## 3.5 Procedures

### 3.5.1 Ethical considerations and potential distress

Any form of therapeutic work and research should be approached with integrity and with an aim to relieve, not cause, suffering. A project with a focus on compassion should hold that

intention at its core. The nature of the relational trauma which my participants had experienced, with its impact of self-blame and shame made all co-researchers vulnerable which needed to be treated with sensitivity (Liamputtong, 2007) and vigilance. In particular, I was aware of the enormous courage and trust that the co-researchers showed in consenting to be part of this research and this is a responsibility which I held seriously. This was reflected in my approach with the women each week and in my correspondence with them.

I am committed to an ethical code which includes beneficence (a commitment to promote our client's wellbeing) and autonomy (respecting a client's right to be self-governing) (BACP, 2016). Given the interpersonal trauma that the women had experienced, there was always the potential in this research that we would explore some difficult concepts which could be distressing. Equally, the research was situated within women's lives, with all the daily challenges they were experiencing and having to deal with, which meant that there were times when the group was able to provide support for difficulties external to the group.

I was always aware that our weekly sessions covered three hours together and 165 hours apart. The challenges of their lives continued whether this was at work, within relationships or anniversaries of significant events. Safety was always of paramount importance to me – even well intentioned warmth and empathy from me and other group members might have been a trigger for memories of past grooming techniques where the source of safety may also have been the source of threat. I endeavoured to manage this early on with the psycho-education session about what triggering is, how that manifests in the body, demonstrating ways to regulate affect early on and to ensure support outside of the group (seven out of eight women were receiving weekly counselling, within the agency or privately, with one on a waiting list) and that all were aware of the Agency Help Line.

Boundaries were always going to be important and difficult for this group (see section 5.3.3). Although there were some email exchanges between sessions I was careful to avoid 'splitting' and developing disparate relationships with group members. I was clear that my contactable email address was checked infrequently and that their established sources of support should be used. In all my exchanges with the co-researchers I strove to be consistent, non-defensive, transparent and inclusive.

From the beginning, care was taken to establish support already in place for potential participants. Prior to the beginning of the research I conducted telephone interviews with all participants during which I asked for a brief history and checked if they were currently receiving counselling either at the agency or privately. I also asked if they were under a Community Mental Health Team (CMHT), if they had a mental health diagnosis, knew of any particular triggers which might be difficult for them or if there was anything else that they

thought would be helpful for me to be aware of. We also talked about their lives; work, studying, family situations for me to assess functionality in daily living. None of these areas would have necessarily excluded any woman from participating, however, it gave the opportunity for the women to reflect on their own mental well-being and support systems and for us to have a clear and open discussion about their current ways of coping. It also gave them an understanding of what the research would be exploring so that I could be as sure as possible that informed consent was given.

Demographical information is captured in Table 1, below. Within the group, one co-researcher identified as Caribbean / White British, the rest White British. Culture is always important but at the time I did not draw attention to the ethnicity in the group as I did not consider it pertinent to the research focus on compassion and sexual abuse. This was later checked with the Caribbean / White British co-researcher to see if, in her opinion, any cultural difference should have been included and she confirmed that she felt any attention drawn to it would have only highlighted difference. This could have impacted on her felt sense of relief in finding similarities and shared experiences with the other women. This choice point of not making ethnicity a focus would, of course, be informed by the client group. Had this, for example, been a group of women who had suffered Female Genital Mutilation (FGM), cultural differences would have played more of a central role in the research. However, on reflection, I think that I could have asked the group the open question of there being any aspects of themselves that might need acknowledging.

| **Co-researcher** | **Age** | **Diagnosis** | **Seeing a counsellor?** |
|---|---|---|---|
| Jade | 26 | EUPD, anxiety | Yes - privately |
| Rhonda | 48 | ADHD | Yes – at agency |
| Christina | 19 | - | Waiting list |
| Sally | 53 | - | Yes -privately |
| Laura | 38 | - | Yes – agency |
| Freya | 29 | EUPD, PTSD, anxiety, depression | Yes - privately |
| Rose | 43 | depression | Yes – agency |
| 8 | Consent withdrawn from inclusion in the writing up. | | |

*Table 1: Demographics of co-researchers.*

In addition to the anticipated support from the group, a ‘Help Line’ was available for all service users of the agency and this was assessable as usual for all. This provided access to an empathic woman (usually who has been trained as a counsellor) to provide telephone support between sessions and in times of crisis. It is checked and responded to within a few

hours, seven days per week. Should any co-researcher have wished to withdraw from the project she would have still had access to this support from the Agency.

### 3.5.2 Information sessions

Ten women replied to the recruitment email and were invited to an information session late in November 2017. This provided the opportunity again to describe the process of action research and cover questions / concerns. Nine women attended the sessions and eight signed up for the research. All were given Participant Information Sheets (Appendix 5) and Consent Forms (Appendix 6) to take away, read, sign and return. Their preferences for when the group should meet were taken and it was agreed to have our first session on Saturday 13th January, 10:00 – 12:00.

### 3.5.3 Confidentiality and anonymity

Confidentiality was especially important for this vulnerable population and was included in the Participant Information Sheet (Appendix 5). Confidentiality of anything discussed during the sessions was agreed by the group in our group rules, discussed and agreed in the first session.

The agency already has a clear policy for confidentiality which assures the service users that their confidentiality will not be broached unless it is considered that there is a risk to a vulnerable adult or child, and then only after discussion with the woman involved. The focus of this work was on the exploration of self-compassion and, as such, other personal and private information disclosed during our discussions that is not directly relevant has not been included in the write-up. Participants were informed that they could request the recording device to be switched off if they shared sensitive and confidential information and one co-researcher exercised this right once during the group sessions. This meant that the dialogue was not recorded, transcribed or included in the research as consent was not given.

I was very conscious of not reducing real women to letters or numbers for the final report and each were given a pseudonym. This gave another opportunity to reflect on anonymity; was it right that only my name is registered against the research if they wished to be heard? Aware that this would be a contentious ethical issue, I decided to use pseudonyms.

### 3.5.4 Consent

Co-researchers were told that they had the right to withdraw their participation and consent at any time before and throughout the project (Appendix 6: Consent forms). This allowed the women to determine their own boundaries, which have been violated in the past. One woman withdrew her consent after the research had ended and her contributions were removed accordingly. In addition, I saw consent as an on-going mutually negotiated process

(Smythe & Murray, 2000) which was reviewed throughout the process. For example, the latent analysis of the data created interpretations which went perhaps beyond their own self-awareness such as the attachment dynamics within the room, or a 'younger part' made herself present and this was discussed with the individual to ensure that consent was given.

Additional consent was also obtained for a third party to transcribe some transcripts, for the Agency office to read their final feedback and for names to given to conference organisers.

An interesting question when knowledge is co-created is who owns the data (Herr & Anderson, 2015) as this holds relevance as to how and where it is disseminated. I was explicit at the beginning of the program that I would be writing up the process as a piece of academic work and gained written consent, but this is something that I came back to as the research began to be written up. For example, when attachment issues played out within the group or 'different parts' of co-researchers reacted to triggers, I was transparent in what would be shared and new consent gained to ensure that everyone was comfortable with what knowledge was shared (Spong & Waters, 2015). Indeed, it was in the writing up that the power imbalances were more inherent as I drew on my clinical experiences to bring understanding to group processes and dynamics (see section 7.8.1 for more discussion on this point).

### 3.5.5 Decisions on how we would work together

One of the first tasks in the first session was to discuss and agree, as a group, how we wanted to work together (Appendix 7).

Importantly, how the group would work together was co-created, not directed, with everyone invited to contribute. A culture of acceptance was created where all emotions were welcome and respected. All behaviour was similarly accepted although contained within the agreed boundaries. Inclusion was also important and reflected one of the quality points of action research; the check-in gave space and voice to every individual (with acceptance if this was declined) and after every session an email was sent to summarise our discussions, to attach relevant material and to thank each woman for their engagement and contributions.

The research group ran for a total of 13 sessions, from 13th January 2018 to 12th May 2018. A request from the group resulted in session times being extended from 10:00 to 12:00 to arrival at 9:30 for a start at 9:45, with an ending at 12:30. Every session was recorded and transcribed except session ten, a psycho-educational session on assertiveness and session twelve, which was an all-day session including mindfulness, visualisations and Tree of Life (Appendix 12). Some sessions were transcribed by myself with the help of an Assistant Psychologist from my workplace (a confidentiality agreement duly signed by her and

additional consent given by all the women), but latterly I transcribed all sessions with the aid of Dragon Speaking Naturally software.

All 8 women who started the research on 13/1/2018 completed it, there were no drop-outs showing the commitment of each individual to the group. However, one woman withdrew consent for her contributions to be included in the write up and this was respected.

### 3.5.6 Agreement of the process and content of sessions

The format / process of the group was agreed in the first session and a laminated copy was available thereafter for the Facilitator to use as a prompt (see Table 2). Each week a co-researcher volunteered to be the Facilitator with no pressure at any time to fulfil this role. A Time-keeper was also sought in each session to keep us on track.

The topic for each session was discussed and agreed with the group throughout the research although I suggested the topics of early sessions as I was aware of the importance of establishing safety early on (Herman, 1997). For example, I suggested a session on coping mechanisms for week three and a psycho-education session on the impact of trauma for week four.

Comments made during the sessions prompted the natural inclusion of propositional knowledge in the form of psychological models. The use of these arose organically from what was relevant to the women rather than me pre-deciding what I thought would be of interest to them. This was congruent with the philosophy of action research; not directing but responding, using my skills in the service of the women rather than holding a more 'doer done-to' positionality (Benjamin, 2004).

I am aware that the models chosen were ones which made sense to me and my worldview; a belief that there is not one truth as a way of understanding our self in the world and that we construct our understanding which is influenced by our relationships which, in turn, are situated historically and culturally. The information shared therefore aligns with the zeitgeist of our time, for example, psych-social models of trauma, ideas from ACT / Compassion Focussed Therapy etc. No doubt if I had been writing this 30 years ago my perspective would have been informed more by cognitive models with reference to the brain as processor of information. All were introduced with an invitation to hold them lightly, embracing any which resonated and were helpful and discarding any which did not. The relativist epistemology therefore was reflected in the content and the process of the sessions.

Congruent with Action Research, a wide variety of content relevant to compassion was invited. Table 2 shows the diversity of content with some brought by myself but, increasingly as the weeks went by, the co-researchers shared material they had found which demonstrated active interest, engagement and commitment in the research. These contributions were either mentioned during the sessions or sent to me with a request to share. Links to internet sites, copies of visualisations or poetry were disseminated via a weekly email sent by me as a summary of the session. There was no pressure to find additional maternal and an emphasis was always made that there was no expectation of the women wanting to engage with any of the material; indeed it was an opportunity to show themselves self-care and compassion by avoiding anything which they feared might be triggering. This was to avoid the perception of anyone feeling that they had failed.

| **PROCESS** | **CONTENT** |
|---|---|
| • Coffee<br>• Decide on 'facilitator' and timekeeper<br>• Check-in<br>• Hopes, appreciations, puzzles<br>• Reflections on last week & journals<br>• Topic of the week<br>• Check out & feedback forms | • Discussion<br>• TED talks<br>• You Tube videos (e.g. Brene Brown)<br>• Poetry<br>• Meditations<br>• Psychological theories (e.g. attachment, Hot cross bun, CBT)<br>• Books (e.g. I'm ok, you're ok)<br>• Websites<br>• Visualisations (e.g. CFT)<br>• Exercises: the cushions, square breathing, tree of life |

*Table 2: The Process and Content examples of the sessions.*

My intention was to try and model compassion throughout in both content and process. This was, I think, reflected back in the activities in our last session which included an exercise of showing appreciation of each other for the woman to take away (drawing round our hands and each writing something in the fingers – see Appendix 12) and a gift from Freya highlighting the women's individual strengths. I also gave a small gift in the shape of a wooden star to thank and mark the part that they all individually played in the research (see Appendix 12 for examples).

A summary of the sessions for each of the three phases is shown at the beginning of the relevant 'findings and analysis' chapters 4,5 and 6) to assist orientation through the three

chapters. This shows the focus of the sessions, the journal question agreed by the group (usually preparation for the following week or reflection on the session) and any psychological models / theories or other psycho-educational material used or sent to group members following a session.

For more information about the power dynamics of the group and my relationship with the co-researchers please see section 7.8.1 ‘Challenges of Action Research’.

### 3.6 Results

A summary of all themes by research question, shown below in Tables 3-5, gives some orientation to the process and demonstrates the unfolding nature of the process:

**Research Question 1: What approaches do they find helpful, if any, to help mitigate self-criticism, feelings of low self-worth and isolation associated with shame?**

| **Phase 1** |
|---|
| Understanding myself |
| **Phase 2** |
| Taking control back<br>Recognising and accepting emotion<br>Understanding myself<br>Understanding others |
| **Phase 3** |
| Understanding myself<br>Understanding and accepting the child part of me<br>From doing to being<br>Altruism |

*Table 3: Summary of themes for research question 1.*

**Research Question 2: What are the barriers to developing self-compassion and can they be overcome?**

| **Phase 1** |
|---|
| The relational impact of the trauma<br>Experiential avoidance<br>Shame<br>A sense of self and self-judgement<br>Secondary suffering |
| **Phase 2** |

| |
|---|
| The impact of developmental trauma<br>Relational schemas<br>Holding boundaries<br>Relating to others<br>Needing acceptance and wanting to please : – trying to get a felt sense of 'I'm okay'<br>Shame: I am not okay and the role of self-acceptance |
| **Phase 3** |
| Greater understanding of barriers |

*Table 4: Summary of themes for research question 2.*

**Research Question 3: Given that sexual abuse is an interpersonal trauma, what is the role of the relationship with the group in developing self-compassion?**

| **Phase 1** |
|---|
| Finding commonality and a sense of hope<br>Seeking kinship / acceptance<br>Altruism: helping / giving back<br>Daring to connect |
| **Phase 2** |
| Acceptance and belonging<br>Expressing emotions and connecting with others<br>Learning with and from each other |
| **Phase 3** |
| Feeling accepted and the importance of shared experience<br>Reflected in the eyes of another |

*Table 5: Summary of themes for research question 3.*

Much thought was given to these themes. For ease it would have been simpler to develop a smaller number of themes, for example, one on 'acceptance' as this was important in each of the phases. However, this would have over-simplified the subtle differences between what I understood the women to be communicating and fitting them into a generic box seemed to be more for my benefit (and that of my reader) than giving justice to their voices.

The co-researchers were asked if any were interested in also analysing the data and identifying themes. This resulted in one woman, Sally also re-reading the transcripts, making notes and feeding back her comments. This was welcomed as a way to fully incorporate a co-researcher perspective and ensuring that the co-participation values at the heart of action research were honoured. It also served to expose anything that was outside of my conscious

awareness, for example, the impact that I had on the group. Sally also found the process deepened her understanding of her own learning and development.

### 3.7 Orientation to the findings, analysis and preliminary discussion chapters

For clarity of communication, I have summarised below results and analysis around the three research questions: what was helpful for self-compassion (research question 1), their experiences of barriers to self-compassion (research question 2) and the role of relationship with the group (research question 3). This has been done, in turn, for each of the three phases of the group: Daring to connect (phase 1, sessions 1-5), Going Deeper (phase 2, sessions 6-9) and Consolidation and Action (phase 3, sessions 11-14).

Direct quotes by the co-researchers are presented in italics with their pseudonym and the week number of the session to clearly distinguish data from description / analysis. I have entitled chapters 4-6 ‘Findings, analysis and preliminary discussion’ as I present the group’s discussions and relate them to psychological theories around trauma. These chapters follow the evolving experience of the women in the group as they explore the concept of self-compassion. The Discussion chapter relates these findings to Neff’s components of self-compassion (Neff, 2008) and considers the broader aspects of the research design for this client group.

# CHAPTER 4: FINDINGS, ANALYSIS AND PRELIMINARY DISCUSSION: PHASE 1: SESSIONS 1–5, DARING TO CONNECT

A summary of the content of Phase One sessions can be found in Appendix 8.

## 4.1 Research Question 1: What is helpful in mitigating feelings of low self-worth, isolation and self-criticism?

| **Phase 1: What is helpful?** |
|---|
| Understanding myself |

*Table 6: Themes around what is helpful in mitigating low self-worth, isolation and self-criticism.*

### 4.1.1 Understanding myself

Table 6 shows just one theme around this research question. Consistent with the literature, it was noticeable that the co-researchers had very few helpful ways of coping, using mostly experiential avoidance (see 4.2.2). However, there was some recognition of helpful ways to mitigate feelings of low self-worth and self-criticism such as walking, singing, cooking, listening to music, being creative, or swimming. It was noticeable that the hobbies mentioned were enjoyed singularly, without relational engagement and some requiring control over the breath, itself an emotional regulation technique.

Detachment was also used a strategy and is included in this section as recognition of it being an attempt to control and manage affect in the absence of more adaptive coping mechanisms (Fisher, 2017):

> *"I like totally detach from everything. I'm detached, I'd say that was my coping strategy. It's easy to detach but I wouldn't suggest it, like don't do that!"* (Christina, week 4).

Although not necessarily noted as 'helpful' initially, an early session using psycho-education (Week 4) gave a framework for the women to recognise and understand their own trauma responses to overwhelming, disorganising hyperarousal (Bromberg, 2011). The structural dissociation model (van der Hart, Nijenhuis & Steele, 2006) resonated with one co-researcher who could recognise that she had different parts, including the 'going on with normal life' part (Fisher, 2017, p.5):

> *"It's kind of like I'm growing up, there's two parts of me. There is one part that's the adult that has to go to work that has to do everything and then there is the other part*

*of me that wants to go out and like partying every night or like typical teenager does. Or wants to snuggle up to my mummy".* (Freya, Week 4).

For another co-researcher, whose abuse stated at a very early age, understanding how there can be an ethereal, sometimes hazy quality to the memories, due to the incomplete processing of the brain, helped her to understand her own questions over her abuse:

*"I have had many people that have said that I'm lying and I'm a fantasist and whatever, regardless of any medical medicine that I have which I do, and everyone has said that. And then I think maybe they are right, maybe..."*

Freya spoke of the importance of understanding: "*Coz like, if I can understand it then I've got a way of being able to sort it out, control it".* This supports our awareness of the psychological need for cognitive understanding as a basic human motivation (Maslow, 1954). This 'waking up the frontal lobes' (Fisher, 2014, p.57) was a chance for the integration of fragmented parts of self where physiological trauma responses can be recognised and accepted for what they are; automatic biological responses as protective measures. This understanding of trauma responses is well covered in the literature although none of the women had been given any psycho-education on it in their individual counselling sessions. However, as Sally noted in her analysis, during Phase One there was still a disconnect between cognition and affect and this integration only slowly developed throughout Phase Two.

The epistemological position of multiple truths was explored in the journal question from Week three when the women reflected on 'how have I noticed I have been affected by trauma?'. The invitation was to write this as 'sometimes I notice…' to start relating to thoughts as something that we *have* rather than something we *are*, therefore undermining cognitive fusion (Luoma, Hayes & Walser, 2007) and the idea of one truth. The feedback from this task for some co-researchers shows the challenge of critical reflexivity:

*"And I tried to turn it round, like how you said to turn it round by saying "sometimes I'm this.." but I just can't do that because I think that I'm 'this' all the time, so, yeah, I've struggled with that."* (Jade, week 4).

While it is reassuring for others:

*"It's not me as my personality, it's my reaction!"* (Rhonda, week 4).

## 4.2 Research Question 2: What are the barriers to self-compassion?

| Phase 1: Themes from barriers of developing self-compassion |
|---|
| The relational impact of the trauma<br>Experiential avoidance<br>Shame<br>A sense of self and self-judgement<br>Secondary suffering |

*Table 7: Themes from 'barriers to self-compassion'*

In contrast to the one theme in Table 6 for what was helpful, Table 7 shows five themes recognised as barriers to self-compassion.

### 4.2.1 The relational impact of trauma

In Phase one, the majority of discussions within the group, both around the weekly topic and during check in, centred on the daily difficulties experienced by the women. Although specific histories of the abuse were never explored outside or inside the group, all of the co-researchers, except one, experienced sustained sexual abuse by a family member or friend of the family from a young age when the natural instinct is proximity-seeking behaviour for survival (Fisher, 2017).

The relational impact of the trauma manifested in every corner of the women's lives. They spoke of problems with intimacy, their heads telling them that they were safe with long-trusted partners, their bodies remembering past trauma and telling them otherwise (Rothschild, 2000). Others avoided relationships or sabotaged them *"I've tried to ruin it like a million times"* whilst another co-researcher found herself having sex as a way to prove that she is 'normal' and spoke of general confusion around the role of sex in relationships: *"if they don't want you sexually then they don't want you".*

All spoke of psychological damage and difficulties with affect regulation: anger towards men *("there's so much anger, I should take up boxing!")*, anxiety for other women's safety around men; feeling responsible for and blaming themselves for everything. A common element was the dysregulating impact of childhood trauma being out of conscious awareness, leaving them 'consciously confused and unconsciously controlled (Gabbard, 2014) *"why do I think like this?"* and *"I'm 48 and somehow still it's affecting me!"*

> *"Because it's not recent you almost feel like 'I should be able to deal with that now and I should be able to be, not over it, but I should be able to cope with that now' "*
> (Jade, Week 3).

The ubiquitous nature of the disruption to relationships supports the inclusion of this in the category of Complex PTSD (6B41) in the ICD-11 but is seems rarely addressed in trauma

interventions. Where it is addressed, it is usually within a therapeutic dyad. For example, both accelerated experiential-dynamic psychotherapy (AEDP) and emotion-focussed therapy for trauma (EFTT) hold as their aim to address relational issues including intimate interpersonal relationships through the strength of the therapeutic dyad alone which they see as then generalised to other relationships, thus restoring the client's capacity for interconnectedness (Fosha, Paivio, Gleiser & Ford, 2014). This strikes me as a mammoth task for 20 weekly sessions of one hour each (EFTT). As a treatment for relational trauma I also wonder what happens after the 20th session when the emotional engagement and connection ends and the client has to adjust to perhaps not so unconditionally accepting caring relationship experiences outside of therapy.

### 4.2.2 Experiential avoidance

One impact of the trauma which was discussed repeatedly was experiential avoidance and its prevalence and commonality deserves its own theme. The concept of aversion to the inevitable suffering which occurs in life has long been recognised in Buddhist philosophy as a root of suffering (Mace, 2008) and acceptance practiced within mindfulness has been increasingly incorporated into a range of psychotherapeutic interventions such as ACT (Hayes, Strosahl & Wilson, 1999), DBT (Linehan, 1993) and MBCT (Segal, Williams & Teasdale, 2013).

The use of substances was one way of avoiding overwhelming affect that some of the women used:

> *"And so my brain used everything, everything else but being on my own...Because if I was on my own I would have to process it and if I was on my own sober, um, without nicotine, without drugs, without alcohol, I couldn't bear… because my head was so full of all these different questions, because I need to keep them away [mutter] coz it's so scary..."* (Rhonda, Week 3)

> *"Coping strategies for me is almost one of the reasons I'm here because I just don't have any. When I was younger it was drink and drugs and boys. And now it's… and now what is it? You know, I'm older, I can't do… you know. I don't want to and I'm...[trails off].* (Rhonda, Week 3)

The effort and pain caused by avoiding difficult emotions, labelled as 'dirty pain' in ACT (Luoma, Hayes & Walser, 2007, p.25) was also recognised. Laura spoke of not wanting to *"deal with*" her emotions which was so common place to her she made the analogy of it being *"like walking to me"*. However, the emotion was always there, under the surface, ready to express itself as anger:

*"But then the anger comes out because I'm not functioning.. I'm just, well I am just functioning. Small things will just fill me with anger because I'm repressing and then I am repressing..."* (Laura, Week 3)

Sometimes the women spoke of not being able to avoid or regulate negative affect and the impact of this on their lives. Viewing trauma responses through the lens of the Structural Dissociation Model (van der Hart, Nijenhuis & Steel, 2004) was used to help the co-researchers understand the going on with normal life part being overwhelmed at times with another trauma-related part. For example, Christina's description of her response to an unconscious trigger sounded like a freeze / shame filled submit part of herself which does not want to be seen, cannot make eye contact and tries to self-isolate (Fisher, 2017).

*"if something affects me, but I almost can't talk, like I just don't want to talk to anyone, I can't look at anyone, I kinda just want to be in a corner but I don't and it's a really strange feeling because I remove myself from that corner, I can't actually say what I'm thinking and I almost put on a brave face but everyone can tell that I'm not okay but I don't know how to say it, it's very strange, I kinda go into my own sort of head for, it can be like a week sometimes and I just… everything is bad".* (Christina, Week3)

*"I get really detached and that's been my biggest problem: is realising that it actually is a problem."* (Christina, Week 3).

The session on psycho-education offered the opportunity to understand our physiological response to trauma. This included the difficulty processing trauma memories resulting in confusion around the abuse itself.

The doubt that it happened is described as "the easier option" by Sally:

*"There is a bit of me that doesn't want it to have happened and I think it feeds, feeds that little bit of uncertainty because actually in doubting it in some way if you could convince your brain that actually it didn't happen somehow that feels like it would be the easier option. So I think it's back to human instinct of trying to protect you."* (Sally, Week 4)

*"I don't share with somebody because that's my way of coping because it's not real then, it's like it's not real if you don't share it which all comes down to the main, I've really thought about this, this week, like I've really, really thought about it and I think that it all comes down to 'it's not real if no-one knows about it' sort of thing." (Christina, Week 3)*

The reluctance to be aware and open to all experience, including difficult ones, is diametrically opposite to self-compassion, which is recognising and showing kindness and understanding when we perceive ourselves as failing or inadequate (Neff, 2008) and highlights the challenge of this work (see section 7.5.1).

The ability to regulate affect, taught in the psycho-education session, is a central part of most trauma treatment, for example, sensorimotor psychotherapy but these interventions do not usually attempt to explore the relational issues which are prevalent in CSA.

### 4.2.3 Shame

Shame was prominent theme in all of my literature search reading, described as the 'core emotion' in women who are survivors of CSA (Talbot, 1996, p.11) and featured in one of my research questions: 'What approaches do they find helpful, if any, to help mitigate self-criticism, feelings of low self-worth and isolation associated with shame?

Shame was rarely explicitly mentioned in the early sessions but what was not acknowledged was still communicated through other means, for example, through the expression of anger (Lewis, 1992). Their descriptions of wanting to withdraw and isolate could also be seen as a manifestation of shame.

Shame was discussed in relation to a perception of responsibility for the abuse. Rhonda spoke movingly about allowing the abuse to happen, giving herself equal weight of power within the relationship:

> *"I haven't told anybody because I can't process it myself, but I actually I felt guilt, shame, I let myself do that, it's my fault, because all along my childhood voice in my head has been "It's your fault, you did this" and you doubt that it happened because it's easier."* (Rhonda, Week 4).

And this psychic defense; being bad in a world of good rather than good in a world of bad, a need to feel in control rather than being totally vulnerable (Fisher, 2017) was echoed by Freya in a later session:

> *"I can't imagine myself being a powerless child where I couldn't fight back. And I kinda feel like I should have done and I shoulda....um. I should have spoken out, I should have done this and that and stuff like that. And I can't imagine myself being powerless, like having a lot of control and I had a control of the situation and therefore I could have stopped it but I didn't. And therefore...was it assault?"* (Freya, week 5).

The courage the women showed in speaking about their shame felt profound. I am often aware of a felt sense of a client's shame and within any treatment it is difficult to address. Although it was explicit in one of my research questions I found myself reluctant to use the word in the group for fear of being suggestive of their emotion and any perceived expectation on their part that it was something they should feel. For the same reason, including a section on 'shame' within a manualised programme could be difficult. Here, Rhonda's confession of feeling guilt and shame was the catalyst for others to speak of their experiences, and in that moment the power of shame to isolate was diminished. The space and the holding environment to do this organically demonstrated that they felt safe to show vulnerability and was in direct contrast to their expressions of relational mistrust spoken of in 4.2.1. This again showed the group itself as therapeutic and the fertile ground of space for individuals to bring what is important to them, rather than what we believe is important on their behalf.

### 4.2.4 A sense of self and self-judgement

A couple of women spoke of their confusion over the concept of compassion as related to the self, which hinted at a deeper level of disconnect. The Tronick (1975) Still-Face study showed the dysregulating effect of even transient mis-attunement with infants. The ongoing impact of non attunement and disregard of distress experienced in CSA, is now known to have more far-reaching impact; as well as the ability to regulate affect being impacted, the development of a coherent sense of self is ruptured (DeYoung, 2015). This 'disintegrating sense of self in the presence of a dysregulating other' (DeYoung, 2015, p.22) was articulated in week one when Freya spoke of not deserving self-compassion, " *I have forgotten that I exist",* and echoed by Sally who said *" I don't have* self-compassion *because I don't have a self, my self was taken away".*

The co-researchers themselves did not speak of self-judgement as being a barrier to self-compassion, seeing it themselves as an objective fact that they were, in some way inadequate or wrong. In her analysis of the themes, Sally recognised the empathy the group showed towards victims in a news story on childhood sexual abuse as a familiar reaction of *"what is happening to them is more important than what happened to me"* and a re-enactment of putting another's needs before their own.

Whilst self-judgement was not necessarily articulated, it manifested in other ways. After each session I sent an email to the group confirming the journal question, sending any relevant links, thanking them for their input with a mention that any absent women were missed. When I neglected to name an absent member this triggered a wave of perceived rejection

and abandonment for that co-researcher which, fortunately, she recognised and raised with me. She could see this as a re-enactment of a 5/6 year old child part of her desperately needing the validation of me in my 'parent' role and the tsunami of affect she experienced around feelings of "*doing wrong"* and, she confirmed at a later date, a felt sense of being wrong.

### 4.2.5 Secondary suffering

The session on coping skills (week 3) provided the opportunity to more deeply unpick what emotions the group were trying to avoid and to develop understanding of their responses to them. Bandura (1982, p.137) writes of arousal being generated from two components; as an initial response to an adverse situation and the 'repetitive perturbing ideation' which follows, creating human distress. This evokes double shame – 'shame about the shame' (Bromberg, 2011, p.23) which I often heard voiced in group sessions and in individual therapy sessions in the agency when women would denounce their emotions as 'making a fuss over nothing'.

I presented graphically the concept of secondary suffering being the result of our harsh reaction to our primary, often physiological, response to a trigger:

| |
|---|
| *2nd response*<br>**Our response to that reaction**<br>"I'm pathetic" |
| *1st response*<br>**Our reaction to a trigger (often physiological)**<br>e.g. body freezing in response to physical affection |

This seemed to be a helpful way of understanding emotional and behavioural responses and the opportunity to see how we routinely *relate* to our negative thoughts and feelings, a known factor in reducing relapse and reoccurrence in depression (Segal, Williams & Teasdale, 2013):

> *"I have not compassion for what's going on there (points to bottom box.) I have coping mechanisms for what's going on there (points to top box) which are usually 'how do I get rid of them / avoid them' but actually coping.. because I struggled a bit with 'well where does the self-compassion come in to it?' and I had come to the conclusion that my lack of self-compassion is 'I'm not accepting the bottom box'"*(Sally, Week 3)

The struggle to wrestle with, and challenge, negative thoughts was also discussed. Rose, spoke of:

> "*two voices: one that's beating yourself up and the other one that's 'no! Stop doing that!' And then you beat yourself up and it's' no! Stop doing that!' "* (Rose)
>
> *"Yeah, it's that internal battle isn't there?"* (Rhonda)
>
> *"So you end up arguing against yourself"* (Jade)
>
> *"Yeah! 'Don't do it, don't do it, don't do it…' "* (Rose)

I introduced an exercise as a way to engage with this concept and recognising the layers of self-criticism and judgement that we tend to engage in. Consent was gained and Laura volunteered to use her example of freezing sometimes when her husband wants physical contact. A cushion was placed on her lap to represent this (Box A). How does that feel?

> *"Like you've got a metal cage squeezing you. Like a really tight, tight, tight mechanism that squeezes in, that's how it feels, like I'm being squeezed into a small, and driven down."* (Laura)

Other cushions are placed on her lap which represent the things that she tell herself. She chooses what they represent – thoughts of:

> *"you're nothing, you're nothing, you can't do anything (cushion 2), I'm pathetic (3), you're stupid (4) don't say anything because it doesn't matter" (5)* (Laura)
>
> *"'you asked for it', that's one of my voices."* (Rhonda)
>
> *"yeah! Maybe! Yeah 'you got yourself into this situation (6), you're broken, you shouldn't be like this, you're not deserving of it anyway' " (7)* (Laura)

Laura described the feeling as "being overwhelmed" and was invited to throw all cushions except the first one (representing Box 'A') to the ground. How does that feel?:

> *"well, I feel a lot better, like there's about 20% of the freeze left there."* (Laura)
>
> *"can you manage that?"* (Jane)
>
> *"I can manage that, yeah."* (Laura)

This spontaneous exercise gave the opportunity to develop an observing self (Deikman, 1982) whereby they could notice the judgement that is added to behaviour or emotions. The flexibility of a nonplanned intervention meant that exercises were responses to client need,

an element sadly lacking within manualised programs which have to seek conformity of delivery for statistical outcomes.

### 4.3 Research Question 3: What is the role of the relationship with the group in developing self-compassion?

| **Phase 1: What is the role of the relationship with the group in developing self-compassion?** |
|---|
| Finding commonality and a sense of hope<br>Seeking kinship / acceptance<br>Altruism: helping / giving back<br>Daring to connect |

*Table 8: Phase One themes from being in a group.*

Table 8 shows four themes around the role of relationship in developing self-compassion.

#### 4.3.1 Finding commonality and a sense of hope

From the first session, when the women were asked to introduce themselves, their 'detached condemning observer' (Pines,1990, p.7) filled the room. Laura spoke of feeling *"completely inadequate"* which also resonated with Rose *" I feel inadequate in so many ways, in destructive ways like in relationships"* whilst Jade was overwhelmed with a global self-condemnation, perhaps reflecting the concrete cognitive development at the age of her abuse (Fisher, 2017): *"I don't like anything about myself, I don't think I'm good at anything, nothing. I have no self-worth, I don't think I'm important."*

The impact of meeting other women who understood from first-hand experience and the experience of 'feeling felt' (Siegel, 2010, p.57) was powerful. This went beyond resonance of a left-brain articulation of experience to a right-brain sense of unspoken, implicit knowing and connection, of 'what lies between the lines' (Stern, 2004, p.114). One woman apologised for crying for most of the first session, saying that she usually wouldn't do that:

> "*I've never been in a group like this before and I'm not normally a nervous person so I don't really know why I've sat here crying but so please just ignore the tears, I'm alright, I'll just sit here and blub and…"*
>
> *"I just want to say please, please don't say sorry for crying, you do not need to apologise, we know."* (Rhonda)

This instant transparency of emotion and a sense of hope was very noticeable from the first session. The women spoke about "feeling that they were in the right place", that they didn't need to "be strong" there and hold back emotions. They articulated their hopes for the research; that they could find strength from each other, that reading my initial email made

them realise that their self-condemnation was perhaps linked to their past and that this could be a way to understand that.

From the first session, relief was expressed of finding commonality of their difficulties and discovering the universality of experience, fostering a sense of cohesiveness; identified as one of the primary factors of the group therapeutic experience (Yalom & Leszcz, 2005). Social isolation, and the belief that one is truly alone is particularly prevalent for survivors of sexual abuse, whose experiences are felt to be shameful and held close, not revealed. Here was different, and the acceptance of each other, who shared their own objectified narratives of self-judgement, perceived inadequacies and failings, was the first step in feeling that they belonged somewhere. Christina, the youngest of the group tried to summarise why that was:

> "*There's like an aura in the room which is, like, acceptance and it's okay and that's a really nice place to be".*

Sally's analysis of the findings highlighted the part I had played in creating an environment, which I found more difficult to identify myself. Knowing only that I was a counsellor at the Agency, she noticed the contrast to the usual counsellor / client relationship; here I brought myself equally into the room and, she said, "set the tone" for transparency and honesty.

Sally also spoke of me sharing my vulnerability by admitting that I was both excited and a little anxious in the first session and that I had no idea how the research would evolve. This, she said modelled how to be in the group, giving tacit permission that "you can be yourself here". In my own reflections on the first session I found myself busy with typing up the group rules, thinking about timings and other practicalities, as well as thinking about the content of what was spoken about by the women. However, I also tried to stay mindful that, whilst the therapist concerns herself with problems and issues, the client remembers their feelings and reactions towards the therapist (Spinelli, 2006). Broadening this out beyond the dyad, the women were expressing a felt sense of safety, so essential for survivors of trauma, in a place where they felt emotionally met and accepted and this was the beginning of how the women could work together as a group.

> *"Everything that everyone has said has really touched me and I'm pleased I'm here and really excited"* (Rhonda, Week 1).

There was also a sense of hope that here was a place that they could show themselves and be accepted and an energy over what we were embarking on which helped create an attachment to the group with a shared aim. This created a different dynamic than would usually be experienced in group interventions for trauma or compassion where there are desired treatment outcomes for a collection of individuals.

### 4.3.2 Seeking kinship / acceptance

The need and ability to connect were both background and foreground throughout the research and was palpable from the very first session. The drive to feel not alone in their emotions and to seek kinship was sought continuously, reminding me of Kohut and Wolf's expression 'the hopeless need of the unmirrored child' in seeking feeling met (Kohut & Wolf, 1978, p.423). This was especially challenging for women who had experienced relational trauma who held both the need and fear of attachments to others.

What was also interesting was the consistency of acceptance and affirmation in the response to each other's insecurities, modelling acceptance and compassion. Although this was well received by each woman who was receiving the affirmation, it also provided an opportunity to feel of value for the one providing the reassurance and an opportunity for role versatility, from receivers of supports to providers (Holmes & Kivlighan, 2000). This act of reassurance perhaps served as a relief from the usual condemning self, whilst also, from a feminist perspective, conforming to the social pressure of 'the tyranny of nice and kind' (Gilligan, 2011, p.33). Perhaps this was a conscious need to please or an unconscious way to assuage the harsh critical inner voice directed at themselves. Interestingly, part of Sally's analysis was noticing this pattern, reflecting that she herself did not feel any benefit from the reassurance directed at her, but recognised the role it played for the woman who was doing the reassuring.

Attunement and empathy are non-verbal somatic responses (Fisher, 2017, p.61) and I wondered if something was happening on a deeper level. The *felt* connection of empathy, the *articulation* of it, together with the different modality of *hearing* oneself responding, to another who is describing emotions so readily felt for themselves, modelled for themselves the experience of compassion; their own struggles reflected back to them thus giving the possibility of viewing them from a different perspective. A step perhaps towards the development of mentalisation skills, described as 'seeing ourselves from the outside and others from the inside' (Bateman & Fonagy, 2016, p.5).

The people pleasing and reassuring content of the sessions, in perhaps a projection onto another of what they wanted for themselves, was marked in Phase 1:

> *"You're not stupid, nobody here is stupid. I think we need to reassure and remind each other that we are incredible strong and that's why we're here, we have a voice and we're using it, that's really strong" (Rhonda, Week 2).*

> *"I feel like I just want to give everyone a hug and just say you're all absolutely amazing women and I feel really privileged to be sitting here with you guys" (Freya, Week 4)*

The function of this behaviour on a process level was not brought to the group's attention in this early stage of the research for fear of it being received as shaming, when, for the women, it was one of, or the only, redeeming feature of themselves. The theme of wanting to please in order to gain acceptance and be liked was discussed at a deeper level during the sessions on boundaries in Phase two where it was seen as a barrier to assertive behaviour. Phase three gave the opportunity for reflection at a process level in the group, demonstrating the advancement of the women's abilities to understand themselves at more psychological depth.

### 4.3.3 Altruism: Helping / giving something back

Yalom & Leszcz (2005) highlight the human need to feel needed and useful in society with altruism as another identified primary factor of group therapy. Whilst reassurance in the room had a focus on the interpersonal, the co-researchers also voiced a need to give something back to women they did not know. This was first articulated in week one when the women shared why they were interested in the research, saying that their experience might help others, or that they wanted in some way to acknowledge the help they had received from the agency and respond to that:

> *I hope maybe we can help other people in the future* (Jade, week 1).

One woman, with experience of trying to recruit participants for her own research, reported that she had put her name down to "help out with numbers".

The objectified child, used in the service of another's needs, learns that their value is around the wants of others (DeYoung, 2015) and often manifested in the women's voiced desperate need to help others, often at the expense of themselves. This theme of altruism ran as a thread through the research, voiced as a major motivation for the women coming to the group and a stimulus for the action part of action research. The combination of an inherent psychological need to feel that one has something of value to give, the damage done to this need for one who has been sexually abused with the pro-social opportunities provided by an action research piece of research is explored more thoroughly in the discussion chapter.

### 4.3.4 Daring to connect

The very quick reaching out for personal connection reflected the attachment styles in the group. At times younger parts of selves were in the room; instead of women, much younger, frightened little girls seemed to be present, holding hands in the sessions or texting each other for reassurance before coming (Fisher, 2017). For example, for the second week we

moved our group session to a different room in the building which triggered huge upset for one woman who was physically shaking as she struggled to readjust saying *"stability is in things, not people"*.

The desire to share, to expose vulnerabilities in order to test acceptance, was in direct contrast to what I had read for the literature review around hiding perceived inadequacies and failures from others (Lewis, 1992). What was different here? Clearly, the women who had volunteered for the group had already placed themselves in a forum in which to share, like the research exploring women's narratives around sexual abuse (Draucker, Martsolf, Ross, Cook, Stidham & Mweemba, 2009), it would make sense that, again, the people most struggling with connection would have felt unable or undesirous of joining a group. The group created the safe environment in which the women could reflect upon and then actively share their relational doubts and fears, to voice and test their assumptions rather than isolating or running away:

> *"I'm probably projecting stuff on to various people because of how they're being and what they're doing and that's sparked stuff off in me, it's about me and therefore I am isolating coz that's what I do so I build a big wall around myself and everybody else, I push them all away because I can't… so being here's quite difficult for me. So I nearly ran away this week."* (Sally, Week 4)

By week four, personal disclosures abounded with individual challenges around multiple factors: relationships with mothers, intimacy, work relationships, health concerns and intrusive examinations and telling families about the abuse. Like a tide which had rolled in and drawn back again, the following week there was an expressed desire to pull away from the relational:

> *"I nearly didn't come today. I nearly sent Jane an email to say I can't come back because going from what I said last week I'm really struggling just by being here so that's just where I am really. I did come, but I very nearly didn't."* (Jade, Week 5).

> *"I was struggling to come today. I walked away feeling that I was annoying everybody and talked too much and that's why I wasn't going to come today because I thought I'm just going to annoy everybody again. I hate rejection, I really struggle with it, really struggle. And I realised that, and I've been trying not focus on it, if that makes sense. And trying to see that it's not a negative and it's all in my head."* (Rhonda, Week 5).

What was impressive however, was the recognition of their feeling state, their willingness to articulate it to the rest of the group and their perseverance to stay with and, by not

withdrawing, trying a different behaviour. Like a child learning about their affective state from a parent, this helped the integration of emotions by making them knowable, nameable, sharable and changeable (Wallin, 2007).

It also gave them the opportunity to hear different perspectives and be open to the relational validation that was no doubt also hoped for. Here, Rose responds to Rhonda, taking the opportunity for some critical reflection on her own inability to articulate her vulnerabilities:

> *"I have an appreciation of your honesty because I actually think that a lot of people I feel the same way, I always think, I must be annoying that person or anything I do. I'm like "oh they don't like me" and I think it's amazing that you can share that and be honest about that. For me anyway, you don't annoy me at all, I really appreciate your input."* (Rose, Week 4).

The shattering of attachment that comes when the mother didn't protect (Herman, 1997) and the trauma of nobody being there (DeYoung, 2015), resulting in a view of themselves as unlovable and inadequate, permeated into a need for attachment within the group. Testing out how they were experienced in the group and whether there was acceptance of them was a left-brain articulation was driven by a right-brain need for connection and necessary groundwork in establishing relational safety. This was needed before the potentially vulnerable work around exploring self-compassion was able to properly begin. This was established quickly and totally and, by the end of week five, feedback forms captured this:

> *"The group has come together and it's much more of a sort of family which is amazing."* (Christina)
>
> *"So much understanding, love showing*."(Rhonda)

### 4.4 Group summary of phase 1: what are we learning about compassion?

Throughout the sessions in phase 1, the always prevalent feelings of unworthiness shone through:

> *"I find that* (crying is helpful) *but then I feel ashamed of myself afterwards coz I feel that, I feel that there's other stuff going on in the world at the moment and actually how I feel is nothing compared to what a lot of other people feel so why should I be upset about that?" (Jade, Week 3)*

These deep feelings of unworthiness were the barriers and challenges to developing self-compassion; why take empathy and softness to yourself if there is the perception that you don't deserve it?

I kept getting an image of something soft trying to embrace and soothe something that was already insubstantial and fragile. I began to think about self-respect as a pre-curser to self-compassion which would give a more substantial framework for self-compassion to be applied and asked the women if this made sense:

> *"Whenever I try to remember what the research is about, I kept saying 'self-respect' and then I kept thinking that it's not self-respect but in my head it was always self-respect. So as soon as you wrote that down I thought, "yeah I absolutely get that" because I kept thinking it was about self-respect not self- compassion."* (Freya, week 5).

The others agreed. Self-respect was the link needed to self-compassion and self-respect comes from a feeling of being in control:

> *"I feel I have no control over my own sort of body, thoughts, and not having that control affects everything else because if I have no control there I have no control over anything."* (Freya, Week 4).

I was reminded of the quote 'trauma robs you of the feeling that you are in charge of yourself' (van der Kolk, 2014, p.203) and when I looked again at the themes coming from the weekly sessions, the over-arching one was about a lack of what the women had been calling 'control' and / agency. Table 9 shows the concept of control applied to the barriers to self-compassion identified in Phase One.

| **Phase 1: Links between the barriers of developing self-compassion and control** | |
|---|---|
| The impact of the trauma | I am out of control |
| Emotionally avoidance | Trying to control overwhelming affect |
| Shame<br>I should have fought back<br>It didn't happen | I was not in control |
| A sense of self and self-judgement<br>Not worthy of self-compassion<br>"I have no self" | I have no control (and don't deserve any)<br>No control felt |

*Table 9: Link between barriers to self-compassion and control*

This would link with theorists such as Pierre Janet who hypothesised that repetitive reliving of experiences was a way of trying to combat the helplessness that comes from trauma and a way of gaining a sense of efficacy and power (van der Kolk, van der Hart, 1989).

Stabilisation was needed to counter the frightening feelings of being out of control and overwhelmed by emotions and bodily responses which were not understood or welcome. Efforts to counter these with avoidance or detachment sometimes helped short-term but the coping techniques explored in session five expanded their repertoire of affect regulation strategies. This provided a more stable foundation necessary to then explore other relational concerns such as their lack of trust and challenges around boundaries.

Together the group applied the key of control as a framework within which to understand what was also helpful in mitigating feelings of low self-worth, isolation and self-criticism which is summarised in Table 10.

| **Phase 1: Links between what is helpful in mitigating feelings of low self-worth, isolation and self-criticism and control** | |
|---|---|
| Understanding my reactions to triggers<br>Secondary suffering | Trying to control affect |
| Doing something for me<br>Expressing emotions through music, dance, singing<br>swimming | Taking control |
| Understanding myself<br>Psycho-education<br>Noticing parts | Taking control |

*Table 10: Links between mitigating feelings of low self-worth, isolation and self-criticism and control*

An attempt was made to put this into a framework and is shown in Diagram 1:

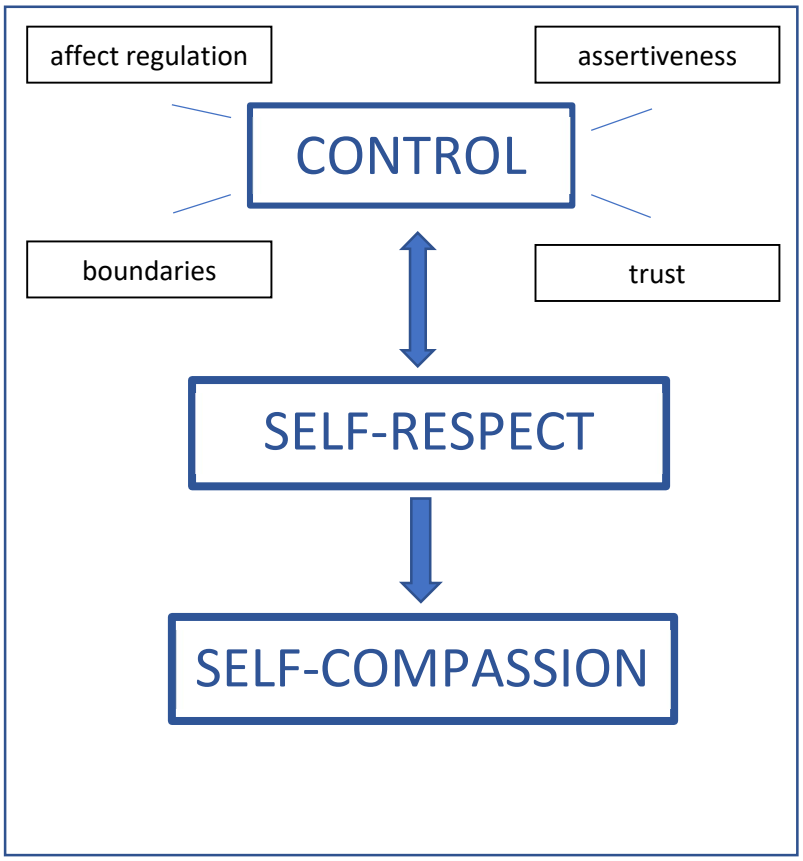


*Diagram 1: A framework for self-compassion*

Once control was spoken about, the room was alive with comments and suggestions; how, at the time of the abuse coercion was used to remove control, the realisation that there is both healthy and unhealthy control, how choice plays a part in when to exercise control.

> *"However, control is a big thing and yes gaining it can be a big step towards self-compassion. I like the framework and it does make sense. Control isn't just about being healthy, not at first, not while someone is trying to gain control in the first place."* (Freya, Week 5).

> *"It's about taking control for ourselves not having the control imposed by the people because to be truly empowered you have to hold the control."* (Sally, week 5).

The formation of a framework at week 5 (which was later refined by the group after further discussion) felt a natural end to what I saw as Phase One. The importance of boundaries in taking and maintaining control, along with the inherent difficulties around this, led to the agreement in the group that week six would be on the topic of 'setting and maintaining boundaries' – and the start of Phase Two.

# CHAPTER 5: FINDINGS, ANALYSIS AND PRELIMINARY DISCUSSION: PHASE 2: SESSIONS 6–9 GOING DEEPER

## 5.1 Introduction

A summary of Phase Two sessions is captured in Appendix 9.

At the end of Phase One, the group reached agreement that a key to developing self-compassion was to first develop self-respect which came from being in control. Control / agency therefore was the overarching theme for discussion in Phase Two with the areas of 'setting and holding boundaries' the topics for discussion in sessions six and seven. We also reviewed the framework in week seven. 'Trust' was the topic for week nine and 'assertiveness' the topic for week ten. In week eight we discussed the impact of exploring compassion together in a group.

## 5.2 Research Question 1: What is helpful in mitigating feelings of low self-worth, isolation and self-criticism?

| **Phase 2: What is helpful?** |
|---|
| Taking control back |
| Recognising and accepting emotion |
| Understanding myself |
| Understanding others |

*Table 11: What is helpful in mitigating feelings of low self-worth, isolation and self-criticism?*

Table 11 shows four themes identified to be barriers to self-compassion. Each will be discussed in turn.

### 5.2.1 Taking control back

Holding belief of personal efficacy, that one's life can be intentionally influenced is identified as the 'foundation of human agency' (Bandura, 2006, p.170). Without this, one is the product of life circumstances, rather than a contributor. With a history where agency was thwarted, overruled by another, it is unsurprising that the perception of agency was a challenge for the women in the group. Where control had been taken, this had a powerful impact on the individual. For Rose, her action was taking the step of reporting her abuser to the police:

> *"I decided to take control so that's when I phoned the police, and reported my stepdad. So it was actually on Valentine's Day because I thought I'm taking back control because it's always on Valentine's Day I'm never loved etc. etc. and the way that I need to start loving myself is to get control back and tell him that he was wrong*

*for what he did so that I get the control back. So that's what I started with, with the control, to then start believing in myself."* (Rose, Week 6).

Rhonda similarly spoke of articulating that a wrong had been committed when she confronted her abuser at a family wedding:

> *"I said to her 'you shouldn't have done what you did. You really shouldn't have done what you did.' "* (Rhonda, Week 6).

This was the catalyst for Rhonda taking control in another way; after that exchange she decided to stop drinking and smoking.

Control / agency was one of the elements the women had identified as being needed for self-compassion and, as shown in the previous section, the discussions were still full of examples of the challenges around this. In early sessions only the couple of examples of control / agency given above could be thought of. However, as the weeks progressed, there were other examples of the women gaining agency by softening towards themselves and experimenting with new behaviours. The impact of this being shared and acknowledged by peers is commented on in section 5.4.3.

### 5.2.2 Recognising and accepting emotion

Phase One discussions on coping had exposed many examples of dissociation from emotions. In contrast, during Phase Two the women spoke of noticing emotions, recognising their function and linking them to what they had learned from the sessions. This was a snippet of conversation in week 5:

> *"The anger and the frustration is my little bit of self-respect, taking me to somewhere where I could sort of sort it and find people who understood."* (Laura, Week 5).

> *"Isn't that 'fight and flight', finding the fight? Something happens and you think "sod it, I'm going to fight this. I'm going to do something about it" and it's the start of it that might then lead to that" (points to framework).* (Sally, Week 5).

For Laura, who had spoken in the first session about both her release and self-judgement in crying, she recognised something else in her ability to hold a difficult emotion:

> *"Last session when I left, and the helpless feeling, that's the one that gets me, that's the one where the sorrow comes when I was driving, and I was feeling the tears and I… and somewhere amongst the tears I sensed, my true self, not in a spiritual way more in a sense of.. I'm just, I'm just, and the only way I can describe it, is love, and*

*just a softness. So if that's me and if that's what crying, through a feeling of helplessness does, then tears shouldn't be a scary thing."* (Laura, Week 5).

The women speaking here had all been able to recognise their emotions, accept them instead of fight them and either self-soothe or reach out for help. Behind this action lies the belief in their ability to do so and some evidence of the cognitive defusion, recognising they were *having* an emotion rather than *being* the emotion. This is in stark contrast to Phase One and their self-concepts of worthlessness and inadequacies (section 4.2) that is so indicative of the shame felt after CSA..

### 5.2.3 Understanding myself

As the weeks progressed, other evidence of a change was apparent. Sally tried the technique of 'square breathing' as a way to control affect whilst dealing with a triggering situation and reported back that (to her surprise) it worked! The impact of the psychoeducation session on trauma started to be felt; Sally admitted in week seven that she had never considered her experience as 'trauma' and this started to bring understanding and acceptance of herself: "*(I'm) realising that, actually your body reacts to things and you probably can't do anything about it."*

Other group members began to show acceptance for themselves in a way that had not been apparent before so that even behaviours like isolating the self and withdrawing from relationships was seen as adaptive to keep safe. Rose recognised that the relational barriers she had been erecting

"*are also protecting ourselves, aren't they? So isn't that, in a sense, being compassionate to ourselves, because we're protecting ourselves?* (Rose, Week 8).

*"What I'm beginning to see is that this self-compassion bit might be; 'stop beating yourself up Sally about the fact that you struggle with it and actually, it's okay to struggle with it, recognise it and find ways…'. I'm beginning to realise what behaviours, which I won't criticise them because they kept me alive, they helped me survive and everything else, they've had their place, but beginning to how some of those behaviours fundamentally get in the way of self compassion."* (Sally, week 8).

For Sally, this increase in self-knowledge could also be related to her attachment style and the impact that still has on the unrelentingly high standards she sets herself.

*"I can now see that I want a lot of that reassurance, more reassurance I recognise that is healthy for me but I recognise where it comes from. I didn't really have a relationship with my mum. I kept thinking if only I was better, my mum would love me. So that's where for me that need to be perfect comes from. My mother, she's in a*

*care home, she doesn't know me from Adam. But there's still part of me that is struggling to let go of: if only I were better, if only I do better, my mother will tell me that she loves me.*

*I struggle all the time with 'if my mother didn't love me, how can anybody else?' And, I struggle with that still, and I think I'm coming to terms with actually, that's not about me, that's about my mother. And beginning to think maybe it's okay to love me."* (Sally, week 8).

The development of critical subjectivity is shown here in the ability to reflect upon their habitual responses to self, bring understanding to them and entertain the prospect of another way of being. The articulation of this in the group gave others the opportunity to hear and share in this new way of managing affect and behaviour, again disabusing the notion of one absolute truth and showing consistency with the epistemology of this research.

### 5.2.4 Understanding others

For me, a step change came when the women started to discuss what Neff describes as common humanity (Neff, 2008); that other people are also equipped with the same insecurities, anxieties and perceptual biases as ourselves and their behaviour springs from this. Neff (ibid) also uses the phrase 'softening of ego boundaries' to bring some understanding and acceptance of others as well as ourselves. Laura demonstrated awareness of this in week nine when the discussion was around 'trust', bringing in her understanding of how our trauma response is triggered:

*"But as we grow into adults sometimes we may catch someone who is in their own head, in their own anxiety and see that in their eyes and instead of processing it normally, like appreciating that they have their own life and their own issues and it's not our unworthiness. The amygdala goes on crazy and we go: 'we're crap. Can't trust them'.*

*The reality is that they're just normal, plain people, like us, human beings with ups and downs and ins and outs.. But it doesn't mean that they're not trustworthy.* "(Laura, week 9).

Paul Gilbert's model was introduced in this session as a way to further understand other people's response to us. This was a realisation for Rhonda and a new way of recognising what might be occurring in her interaction with the colleague she experienced as bullying:

*"But, I've just realised something, perhaps she sees me as a threat because I'm a similar age to her and I'm quite strong and in my own way I'm having an impact on the environment."* (Rhonda, Week 9).

*"You don't know what's going through her mind what she's dealing with at home, or.. And remember that when people are defensive they're either coming away from themselves or attacking."* (Rose. Week 9).

This acceptance of others showed not a passive submission to others but a developing mutual understanding of oneself in relationship to another and a softening of the isolation and mistrust so often articulated in earlier sessions.

*"And so you realise that actually, it's not because they're a bad person, is just the way they were brought up, or their moral compass is totally different from my moral compass so I need to appreciate where they're coming from. So something that is really small to you could be a huge step for them to take."* (Rose, week 9).

It felt that a major step had been made here from critical subjectivity to critical intersubjectivity; the questioning of relational assumptions that can lead to confusion, self-isolation and mistrust. And, again, those silently listening are participating at their own level; providing the audience for those speaking and listening to a new perspective on others' behaviour.

### 5.3 Research Question 2: What are the barriers to self-compassion?

| Phase 2: What are the barriers to taking control back through developing boundaries, assertiveness and trust in others? |
|---|
| The impact of developmental trauma (sexual abuse) |
| Relational trauma schemas |
| Holding boundaries |
| Relating to others |
| Needing acceptance and wanting to please : – trying to get a felt sense of 'I'm okay' |
| Shame: I am not okay and the role of self-acceptance |

*Table 12: Themes from barriers to self-compassion.*

Table 12 shows again the striking impact of trauma on relationships in Phase Two of the research with five out of six themes being around this. Again, the self-directedness design of the research gave room for the women to bring what was troubling and relevant to them rather than this being assumed by another, putting their personal experiences at the heart of the group.

### 5.3.1 The impact of developmental trauma (sexual abuse)

The daily struggles experienced as a result of trauma were continually shared in the check in and were examples of where control was difficult. Fundamental to boundaries, trust and assertiveness was the question of self in relation to others; what can I / should I expect from others? What is my own value or worth in the world compared to others?

The transgression of boundaries in childhood resulted in confusion in adulthood:

> *"Someone hasn't shown you how to have proper boundaries because they've trodden all over them. So how do you then work out when boundaries are wrong?"* (Sally, Week 5)

And I was struck by the powerful imagery of Laura when she said in week 5:

> *"Well, how do you set your boundaries when you've got somebody like a snake coming in?"*

CSA is the subjugation of one individual's needs for another's. When this is in the context of a parental figure this understandably gives rise to a fundamental confusion of self in relation to another and of what constitutes appropriate behaviour. One group member, admitting that her usual position was of "allowing everybody to do exactly what they wanted and thinking that was fine":

> *"I think if I had a really strong sense of me and what's wrong for me and what's right for me then I think the boundary bit would be easier. But I don't think I have."* (Sally, Week 6).

The cognitive turmoil around boundaries was exemplified by Freya's written list of her own boundaries emailed to me after reflection of the journal question around this. The last two points I found particularly poignant:

6. No always means no.
7. I can't say no.

### 5.3.2 Relational schemas

The sessions exposed the women's relational schemas, messages explicitly and implicitly given of how one should behave. When sexual abuse occurs in childhood, especially with a loved member of the family, implicit messages are perceived in the meaning of the interaction.

> *"If somebody loves you then you let them do whatever they want to do"* (Sally, week 6).

And a younger part of Christina's 19 year old self, when speaking of a present day problem in her family declared:

> *"You don't argue with an adult"* (Christina, Week 7).

The 'detached condemning observer' (Pines (1990) showed itself in the labels the women assigned to themselves. Christina acknowledged that a disclosure to her family of the abuse would probably be helpful but held back out of concern for the reaction it would cause:

> *"Just because I'm broken it doesn't mean to say that I have to break other people to help myself"* (Christina, Week 5).

Freya's feared consequences if she spoke about the abuse hinted at a younger part of herself whose silence had been ensured by threats of devastation. In reply to her grandmother, who blamed herself for not asking the right questions which might have prompted disclosure Freya said:

> *"but even if you asked the right questions, I would never have told you. Ultimately, at the end of the day, if you did know then the results of that would have been a heck of a lot more catastrophic to me and the family than what it is now."* (Freya, Week 5).

A fragmented part of the self, perhaps the only part who feels worthy of being loved for being the keeper of family secrets (Bromberg, 2011) is a powerful force. Sally was able to reflect on the power of an adult to maintain the silence of the abused child and why, still, as an adult it was so difficult to express:

> *"I think of fear of hurting others in fear of rejection is part of what was wired into us by what happened. So in other words, you don't tell anyone because they will be hurt. Is it part of my wiring that is forcing me not to say anything. (Am I) wired to keep my mouth shut?"* (Sally, Week 5).

The response to the women's schemas was one of respectful listening and acceptance. This stands in direct contrast to a CBT approach in which thoughts, feelings and behaviours are

'documented and corrected to lead to desired change' (Jackson, Nissenson & Cloitre, 2014 p.244) which, to me, would confirm the women's perception that how they think or feel is somehow wrong rather than an unsurprising outcome from their experiences.

### 5.3.3 Holding boundaries

Throughout the sessions on boundaries, examples were given of the difficulties around developing agency through assertive behaviour. Christina spoke movingly about how 'something is lost' sometimes when boundaries are held, her example of conditional access to family members exemplifying the power imbalance that can be held within families. Discussions were held around the interpersonal nature of our social worlds which is perhaps usually learned at a younger stage and was disrupted in the personal histories of the co-researchers. This relational aspect was articulated by Sally:

> *"No one can be completely in control because there are two people in a relationship. It's learning the balance of the compromise because I tend to feel that I'm either here or here as in I completely give in, or hold my boundaries so rigidly at the other end that it's black-and-white and I think and beginning to learn that it's not quite that simple. What I find difficult is to calibrate and that's where my default mechanism is: either caving completely in and not seeing me at all or be so rigid that I don't see the other person."* (Sally, Week 6).

### 5.3.4 Relating to others

Schemas learned in abusive relationships around trust and boundaries with others were generalised to both friendships and relationships with the opposite sex. Group members could understand and acknowledge the origins of their behaviour but, as Rhonda expressed *"when it's learned behaviour, it's secure behaviour"*, showing the power and attraction of known behaviour (and the challenge of change).

For example, Rose avoided relationships in which she could expect commitment but there is also an underlying tension in her words about the vulnerability of true connection:

> *"I would only go after guys who would hurt me. Because then I couldn't attach to them. So I would be 'the other woman' or be with somebody that wouldn't properly commit to me and I would know, getting into it, that they would never properly commit to me (a sex buddy). So therefore, in my head, I know that they are going to hurt me, so they're not gonna hurt me, but actually it hurts me even more."* (Rose, Week 8).

Rhonda held somewhat divergent views on the part she plays in relationships with others. On the one hand, she spoke of a schema of isolation and of forced self-reliance:

*"Nobody wants to protect me, nobody wants to hear me, nobody wants to be there for me, I'm on my own, so it's all about me."* (Rhonda, Week 8).

At other times she spoke of the responsibility she took for damaging relationships through her insecurities:

*"I've realised that I can form relationships but it's the bit afterwards that I can't do. I seem to destroy it, I get so terrified of saying the wrong thing, doing the wrong thing, making the wrong thing. I'm single, I live on my own. I don't think I could ever live with anybody else. I don't think they could live with me."* (Rhonda, Week 8).

Again, the damage done from a relational trauma was replayed again and again in other relationships, showing the need for this to be addressed in interventions for complex trauma.

5.3.5 Needing acceptance and wanting to please: trying to get a felt sense of 'I'm okay'

The theme of 'wanting to please' was noticed in Phase One and continued to be a major topic of discussion in Phase Two. As a way of understanding assertiveness and as a response to the written feedback received by group members on assertiveness, we discussed the 'I'm okay, you're okay' (Harris, 2012) model in week six. The recurring theme around the topics of assertiveness, boundaries and trust was a drive to please, to feel approval or acceptance from others and to, at all costs, avoid rejection, which, in terms of the Harris model felt like a striving to feel 'I'm okay'.

At the mercy of self-damning judgement, known to be a common response to sexual abuse in childhood (Talbot, 1996), the women described how they looked for approval and validation elsewhere. Rhonda could recognise this in herself, even looking for friendship from a work colleague who she described as bullying and had publicly shouted at her:

*"It's a learning process, I know that I crave that woman at work, I crave her laughing and smiling and coming over and saying you alright R? I crave that even though, I don't want to! I'm just as good as her! Not that I'm trying to measure myself against her because I am a different person and I know that she comes from her own sphere. But when she's normal to me it makes me feel 'oooh' "* (Rhonda, Week 9).

The need for approval from others, perhaps a re-enactment of the little girl who wants to please and do as she is told, shone through with the women's own reflections of their behaviours:

> *"I really struggle with this particularly saying 'no' to others even when they expect too much of me - I would rather put myself out instead of other people being put out, even if it's not my responsibility or nothing to do with me."* (Jade, Week 6).

A different re-enactment perhaps lay behind Rhonda's hyper-vigilance for other people's emotional states:

> *"I'm really happy when people around me are happy and I try to be perfect, not because of them but because I think it's what I have to do for me. I am able to relax because they are happy."* (Rhonda, Week 8)

When a child has been objectified; treated as an object for another's needs, a propensity for holding a sense of self as an object for others is learned (DeYoung, 2015). A fear across the group was that they would be rejected, or thought badly of, if they did not acquiesce to other's demands or requests. Freya wrote to me about the guilt she felt if she *'let people down or be late anywhere and I will spend days being hard on myself for it or any other mistake or perceived upset I may have caused'.*

Sally was able to reflect on her emotional response to me when she felt I had not given her equal attention. After an email in which she brought this to my attention, in the next session she contributed far less than usual and I felt a sense of unease as she watched me constantly. After the session she asked to speak to me alone and confessed that her vigilance of me was because she had been expecting me to hit her. She explained that her 5/6 year old self had felt that she had 'done wrong' in speaking out to the adult and she waited for the violent repercussions learned in her childhood which would automatically follow. Whilst one conversation had been happening within the room, a different one was being played out between our limbic systems (Bromberg, 2011).

The opportunity provided by the group of developing an 'observing self' (Deikman, 1982) where emotional reactions and behaviours are noticed and reflected upon, meant that Sally was able to come back, articulate this to the group / myself, test for accuracy of her thought process, normalise on why she had this reaction and create new understanding. This process of bringing to the group is discussed more in a later section.

### 5.3.6 Shame: I am not okay and the role of self-acceptance.

At times, the women exposed a deeper level of anguish, an intrinsic sense of themselves being bad or unworthy of respect. This could not be comforted and reassurance was not sought from others, nor given by others. Laura spoke of the fear of transparency of the parts of her that hold the shame, risking any sense of cohesiveness of self (DeYoung, 2015):

> *"But for me, just the thought of some man, turning around and, with all their power, because they do have all this power, their strengths, turning around looking and just being like (makes dismissive noise) or saying something like "who are you? What have you done with your life?" It's like sometimes I feel I have see-through parts of me that I am ashamed of and they will say something like "you're just a slut. You were, that's who you are. You deserved that" or something like that"* (Laura, Week 6).
>
> *"It's hard to gain back control after everything. And for me when I don't have control I can't be compassionate towards myself. Why? Because I don't deserve it."* (Freya, Week 5).

This complete lack of self-worth became poignantly apparent in the discussion around the impact of telling family of the abuse and hurting them. while others spoke of the fear of hurting others, Jade had a different perspective:

> *"I didn't feel that I was valued enough that it would hurt anybody else. So mine was a fear of being a burden to other people and taking on my problems rather than anything else."*

Cognitive understanding of propositional knowledge, was recognised as helpful, but not enough. Sally expressed her frustration at herself for her inability to accept herself without judgement, which she saw as the foundation of her inability to connect with self-compassion.

> *"I get it, but then it's actually changing it. I know I have a problem and secure attachment is the route to that. And whilst I get all of that, somehow having that gentleness with me to say 'you know, that's how it is and that's a bit of the difficulty, but it's okay', that's where I fight it. So although I may understand it up here (gestures to head) I don't have the connection between here and here (head and heart) and that doesn't let in that self-compassion."* (Sally, Week 8).

The awareness of this disconnect that Sally speaks of, a lack of 'vertical integration' (Siegel, 2007, p.296) had already been mentioned by her when she spoke of not wanting to connect with her emotions through music. At this stage of the research she struggles with 'unconditional presence' (Glaser, 2005, p.12) where she can both 'see' herself and is also able to 'feel' herself.

The unprompted articulation of their deepest shame around self-value was 'held' in the room with respect. A CBT approach here might have looked to alter their schemas but I wonder if any cognitive reframing could possibly have touched the depth of their subjectivity which was a body based sense of themselves as undeserving of love or respect. Nothing was offered to

'fix' or change these feelings but they were heard by the women who could resonate with the expressions of unworthiness.

## 5.4 Research Question 3: What is the role of the relationship with the group in developing self-compassion?

| **Phase 2: What is the role of the relationship with the group in developing self-compassion?** |
|---|
| Acceptance and belonging |
| Expressing emotions and connecting with others |
| Learning with and from each other |

*Table 13: Phase 2: Themes from being in a group*

Table 13 shows three themes from the role of relationship.

### 5.4.1 Acceptance and belonging

The platform of finding commonality and acceptance within the group from the very first session developed into the sessions being experienced as a safe space within which any personal disclosures would be met with warmth and understanding. At the end of check-in at each session we incorporated, at a group member's suggestion, a section called 'hopes, appreciations and puzzles'. This became a specific opportunity for an expression of group member's felt sense of safety where they felt they could be emotionally congruent and still be accepted:

> *"Appreciation - to the group. Because this week, like last week, I feel really comfortable, I feel very comfortable and I feel like I can say whatever I want to say and nobody is going to… I feel like everyone cares which is really nice. There is nobody here I feel like wouldn't care and that is amazing to me."* (Christina, Week 6).

> *"It's really helping me because it's like an anchor, like a positive anchor. I know that, every Saturday morning, there's a group of women who I'm going to be around and I … what their sharing is helping me to find me and helping me to see the world is not such a cruel and lonely place."* (Rhonda, Week 8).

There was a real sense of belonging and deepening connection developing in the group which countered the trauma response of erecting interpersonal barriers spoken about so widely in Phase One and discussed in the 'barriers' section above. This gave a different experience of relationship with another in the here and now, one in which personal disclosure was met with acceptance and empathy which, in turn, implicitly encouraged

further disclosures and the taking of interpersonal risks (Yalom & Leszcz, 2005). The space to share at this level was a particular feature of this action research therapeutic group which is not always available in manualised programs and yet it is where the reparative attachment bonds were made and a perhaps novel experience of oneself in relationship with another felt.

Where there was specific feedback to a group member it was noticed to be more praise and admiration for personal disclosure rather than words of reassurance, which, as Patrick Casement tells us, doesn't reassure (Casement, 2013):

> *"Appreciation (looks to Jade). I know you found it really tough last week but the honesty with which you expressed why you were struggling and how you felt, I think… I really appreciated it and it helped me to understand you a bit better. Thank you."* (Sally, Week 8)

As connections within the group became more secure, group members were supporting each other both outside of the group as well as in. One group member, Jade, had spoken of a difficult anniversary day approaching. Laura responded:

*"Whatever tomorrow is for you then, text, call, you know, anything you want. I don't have any particular plans and my heart goes out to you, it really does. Big love and whatever you need today in the session, if I can help…* "(Laura, Week 9).

And absent group members also played a role in supporting others:

> *"My appreciation is to Sally, who is not here, for calling me this morning when I said I was a bit nervous. And, when I spoke to her earlier she said to send her love to everybody and she misses everybody."* (Laura, Week 9).

Perhaps the most profound appreciation of the group came from Rhonda

> *"And I'm only just, this group is helping me, this whole journey I started on last year is helping me to realise that it was not my fault."* (Rhonda, Week 8)

### 5.4.2 Expressing emotions and connecting with others

One group member, Christina, drew the group's attention to the research questions (always on display in the room) and queried whether we were paying enough attention to Research Question 3: Given that sexual abuse is an interpersonal trauma, what is the role of the relationship with the group in developing self-compassion? It was agreed that this would be the focus of session eight which was an opportunity to explore this in more depth.

A strength of exploring self-compassion within the framework of action research was the opportunity to make explicit what was both content and process within the group, which perhaps would not usually be included within other research methodologies or trauma interventions. This allowed 'horizontal integration' of the non-verbal, felt sense, right hemisphere experiences within the group to the articulated, cognitive understanding of the left hemisphere (Siegel, 2007, p.300). Of course, 'something is gained and something is lost when experience is put into words' (Stern, 2004, p.144) but it also gave space for critical intersubjectivity as the women could explore their own process as it related to another's.

It also served, I think, to reinforce the flattened hierarchy of us as a group together, encouraging their trust in me to be open and transparent in everything and showed that their opinion was sought after and valued. The discussion on how being in a group was helpful towards developing self-compassion opened the door to reflecting on the value of allowing feelings to be acknowledged and experienced, rather than the avoidance which was discussed in the early session on coping mechanisms. They reflected on why being with other women was helpful and spoke of being able to be honest, that feelings were welcomed and permission given for them to be expressed in this space. This sharing of how they felt, to others but importantly to themselves, in itself was an expression of self-compassion, decided Jade. There was also the burgeoning realisation that because of the commonality of shared experiential knowing, compassion for another could be compassion for themselves:

> *"I have been able to be more honest than I've ever been because what I've heard around me has made me reach, I want to be compassionate to other people, which has allowed me to be a bit more self-compassionate and a bit more aware of it and feel it because of the person next to me"* (Rhonda, Week 8)

What was not explored, but might have been in a more traditional therapeutic group, were any underlying tensions in the group. The women did not raise this and I did not wish to direct, or steer, their discussion. This might have yielded important understanding of themselves in relationship but, with our timebound topic exploring self-compassion within the framework of action research, this was not covered.

### 5.4.3 Learning with and from each other

The learning from each other element was more noticed and expressed in Phase 2. The benefits from doing this research as part of a group meant that therapeutic gains in terms of insight was achievable from group members who were listening to other women's disclosures. An example of this was when Rhonda spoke of "your honesty helps me to understand what is still locked up" in week seven. Freya also noticed the personal impact the

group was having on her and contrasted the therapeutic benefits to what her expectations had been when asked to join a research group:

> *"I don't how many people really knew what they were getting themselves into, but my thoughts have really changed in this is more of a supportive group and something I have been learning from rather than 'researching out'."* (Freya, Week 6).

The closeness of the group and the weeks of nurturing relational interaction also gave the opportunity to hear how they were being experienced by others in the group, allowing perhaps the chance to reframe their self-assumptions.

An example of this came midway through Phase Two. After personal disclosures in week five Sally had asked to be excused from the room for a short time and then returned, quiet and pensive. After the session I found myself anxious that she was distressed from the session and reflecting on any part I played in this and if there was anything else I should / could have done to be more 'holding'. Sally emailed me expressing her anxiety that she had 'overshared' and worrying about what the group had thought of her. In the following session, unaware of any of this Laura ended her check-in as follows:

> *"It's not really appreciation it's more like the upmost respect. And excuse me if I get emotional, but to Sally specifically, I just think it was amazing to talk like you did last week and I think that that's just, well, 'wow!' So, I just think it's great that you can tell your story like that, in such a good way and as such a strong way as well, and I hope that something to be able to do myself one day."* (Laura, Week 6).

Like Yalom's writing of 'twice-told therapy' (Yalom, 1990), this multi perspective example was a reminder that our truth is of our own making, that there is the human tendency to put ourselves centre stage in every situation and the potential gains from hearing another's point of view.

The group was still used to normalise behaviour. Group members would notice their own reactions or behaviour and ask others if they noticed this for themselves. This was another way to not feel alone in their emotions and for interpersonal connection to foster a sense of common humanity. For example, Sally was aware that she assumes rejection in relationships and therefore pre-empts this by driving them away by her behaviour:

> *"I test and test and test. I will do my damnedest push somebody else away because then they haven't hurt me, I'm in control because I expect it to end in the rejection so somehow or other I kind of force the rejection on my terms. I'm getting lots of 'nods' with that."* (Sally, Week 6).

The bond within the group also fostered a joint sense of achievement when group members spoke of new behaviour which showed self-compassion.

> *"When three or four of you were talking I was doing like mini dances inside and egging you on. It's like a mini win and whenever anybody has a mini win I feel that, being part of this research, we all should feel part of that mini win as well because technically we're here to support other people who aren't here as well."* (Freya, Week 9).

The recognition of each other's successes reinforced the experience of belonging to a group with shared values and aspirations, creating a group identity. There were no individual goals which might have created a sense of rivalry or unfavourable self-comparison which might be present in other group programs. The importance of the group is discussed more in section 7.3.

### 5.5 Noticing moments of self-compassion

All of the women had begun the research with a marked negativity bias, the trauma brain alert to perceived threats or assumed danger and a narrative of self-condemnation. As the research progressed, the women used check-in to share examples of noticing moments of self-compassion which was experienced in the moment, held as a memory to bring to the group, re-lived when spoken about and then accepted and validated by the others. This process gave the opportunity for a different way of experiencing themselves, with the potential of new neural pathways towards self-compassion and away from self-damnation.

For example, Laura noticed that her behaviour towards herself had changed in a different way. In her week eight check-in she spoke of "a moment of self-compassion, which was quite profound' as she questioned what she needed:

> *"I was alone in the house and without knowing my mind was going through what you going to do? What are you gonna do? And I work very hard, and I'm dealing with this, and I am told by people just become that yourself. So I decided to walk my dog. My dog needed walk and then I thought, I just need to give myself some space. And I felt compassionate about myself so I decided to not think, and concentrate on the physical aspect of what I was doing."* (Laura. Week 8).

Any shift in self-perception needs to be both 'felt' and cognitively known. The innate desire for understanding, has been suggested as basic as our needs for safety, love and self-esteem (Maslow, 1954) was demonstrated in the group. For example, Rose spoke one week about her change in perspective:

*"The penny that has really dropped today is "be gentle with yourself. Be gentle with yourself." And that's not about wrapping yourself in cotton wool it's about being gentle. So that's not about being selfish or ignoring others or anything like that it's just about being gentle."* (Rose, Week 8).

Other examples of different behaviour were brought to check-in. Rhonda noticed that her assertiveness was manifested through the boundaries she was setting:

*"You have made me realise that I am setting new boundaries, like saying to you Jane that I need to leave earlier and go for a walk before I go to work. I've been messaging my friends saying that, because I do the research in the morning, there is no way that I can meet anybody for coffee."* (Rhonda, Week 9).

Other new behaviours were also brought to check-in. Christina spoke of deciding to speak openly to her best friend about the abuse she experienced. As her friend had afterwards been in a relationship with the perpetrator this had always been avoided:

*"I had never spoken to about her ever … Even though I felt really angry, I had like never brought it up because I think I didn't want to deal with it. But I did bring up with her and it was really, really amazing to do that. And she kind of, I think that she, started to realise as well. We were so young I don't think we realised what was going on, and how that was wrong or anything like that and she was, like, talking to me about it and it was really amazing that she didn't shut it down, like she opened up a conversation about it and it was really amazing. So I've had is quite a good week, in a weird way, it's been quite sad but it's been like really good as well, I feel like a massive weight has been lifted this week."* (Christina, Week 6).

### 5.6 Group reflections of phase 2: revising our framework

These deeper discussions prompted a revision to our developing framework of self-compassion. Jade felt that something needed to come before control, something she labelled as 'validation'.

*"I feel that something comes before control and I don't know whether it's validation, I don't know whether it's trust because I was… so I have to have that before I can take control. I'd have to have that trust or validation or that validation of myself or trust in*

*other people. I don't think the control can just come from nothing. I think that you have to feel you're worth something enough to take control."*(Jade, Week 10).

The group grappled with articulating their own felt sense of what was lacking in the framework. Language was sometimes unclear and confusing; different words used for the same concept, different visual representations used to graphically display ideas where words seemed inadequate. A framework was put forward which seemed to convey what was felt in the room. Everyone agreed that there could not be a linear path to self-compassion and that there is a complex interplay between different factors.

The framework presented some clarity in what was needed for oneself in order to reach a level of self-compassion. Diagram 2 shows 'Self-acceptance' has been added to the framework, an essential ingredient all women agreed upon, reminding me of DeYoung's statement that 'shame persists when self-acceptance remains out of reach' (DeYoung, 2005, p47).


*Diagram 2: A revised framework of self-compassion.*

Whilst Phase One was a period of developing group cohesiveness and an outpouring of the long shadow of CSA, Phase Two was a more focussed endeavour to grapple with the benefits and challenges of a sense of control in setting boundaries, being assertive and in trusting others. And whilst this was the content of the sessions, the value from doing this with other women who felt safe and who showed non-conditional warmth and acceptance was

becoming to be more and more evident. The women had found a place to share their most tightly held judgements of themselves in relation to others, to understand how the past was playing out in the present and that it was possible to relate to themselves in a different way.

> *"I thought, my way of surviving the world, to be happy and healthy in the world, was all of the behaviours I learned as a kid and I have now, at the ripe old age I am now, have realised, that doesn't allow you to be in the world in a happy, whatever way. It allows you to exist in the world, but not be <u>in</u> the world."* (Sally, Week 8).

The women were keen to share what they had been learning and elected to produce newsletters which could be emailed to other service users of the agency; an example of practical knowing in the extended epistemology of action research (Heron & Reason, 1997). These would be sent out fortnightly on topics which had been covered in the research. Importantly, it would be written *by* service users *for* service users, stressing their experiences in order to normalise the challenges the faced every day as part of childhood trauma responses to emphasise that there was a connection between them. The co-researchers decided to call themselves #wearenotalone to emphasis this point in their communications and send out the newsletters under this name.

# CHAPTER 6: FINDINGS, ANALYSIS AND PRELIMINATRY DISCUSSION: PHASE 3: SESSIONS 11-14 – CONSOLIDATION AND ACTION.

## 6.1 Introduction

Phase Three of our research started with an all-day session and shared lunch. The longer time period gave an opportunity to explore some mindfulness practices, visualisations and CFT activities such as building a compassionate image. We also used the time to plan what would be covered in the newsletters and agreement of who would write each one. One member of the group, Jade, who in the first session spoke of feeling that she was not "good at anything, nothing" and of "no self-worth", discovered that she was particularly good at graphics, offered to take the written text and put it into a newsletter format (Appendix 11).

The focus of the remaining sessions was a consolidation of what we had been covering throughout the research: week twelve covered a review of the research questions, week thirteen was our final session with a session two months later as a follow up. In this stage of the research there was little talk of barriers to self-compassion, more on what had been helpful and, in particular, what impact exploring the topic of self-compassion together with other women with similar experiences. Again, the themes and analysis in this section follows the order of what is helpful (Research Question 1), the barriers (Research Question 2), and lastly the impact of being in a group (Research Question 3).

A summary of the content of Phase Three sessions is captured in Appendix 10.

## 6.2 What is helpful in mitigating feelings of low self-worth, isolation and self-criticism?

| **Phase 3: What is helpful?** |
|---|
| Understanding myself |
| Understanding and accepting the child part of me |
| From 'doing' to 'being' |
| Altruism |

*Table 14 : What is helpful in mitigating feelings of low self-worth, isolation and self-criticism?*

Table 14 shows the themes around what was helpful in developing self-compassion in phase 3. It is interesting to note that control / agency, identified as important in Phase One and the focus of Phase Two, was not explicitly discussed in the group during Phase Three. However, I would argue that it was implicit within each theme. For example; the first two themes were around gaining increased awareness and control of affect. In addition, the feeling of safety

created in the group  gave a sense of security within which to explore that. Arguably the examples of increased self-compassion came as a product of that control.

### 6.2.1 Understanding myself

Yalom & Leszcz (2005, p.93) write of pure cognizance – the innate desire for knowledge and understanding and the benefits of this to help mitigate anxiety and to lower both physiological and psychological signs of stress. The realisation that their reactions could be understood within the framework of a trauma response was the first topic when the women were asked in week 12 what had stood out for them from the research. Sally spoke of being more understanding of herself now that she understands "*what is going on in the body bit"*. For her, it wasn't trying out 'helpful' approaches but rather *"understanding the barriers and working was going on and then finding a way to pause, so when everything is kicking off in my head it's pressing the pause button enough to give me a moment to think about one"* was the most helpful. Freya echoed this, finding the information about the Broca particularly helpful.

For others, understanding what triggers are and how they impact on them was *"freeing"* (Laura, Week 12) and gave the opportunity to "*recognise and deal with them"* (Freya, Week 12).

The recognising and accepting emotions which was noted as a theme in phase 2 continued to be developed in phase 3. In these later sessions the women again demonstrated a different relationship with difficult emotions (discussed in the barriers section) with a developing ability for meta-cognition and critical subjectivity. Freya, using knowledge gained from the sessions, spoke of neural pathways and the negativity bias:

> *"We've got to almost change our brain pathways to allow ourselves to give up some control and put healthy control in place in order to get the self-respect, in order to be compassionate to ourselves."* (Freya, Week 13).

What was striking for me in this was the evidence of hope in the possibility for change and a stark contrast to Freya's introduction of herself in week one where she spoke of forgetting that she existed and having *"lost myself so much that there's nothing to be able to build up"*.

Sally too recognised the developmental aspect to her way of seeing the world. She spoke of missing out on the instinctive need for nurturing and respect that is a normal part of growing up and the struggle thereafter to meet this unmet need:

> *"It could be repeating patterns of when you're young that you are trying to get the nurturing as a child you didn't have. How do I turn that into the support I need is an adult?"* (Sally, Week 13).

Freya could link this to her need to nurture others in the hope and expectation that they will give this back whilst Jade struggled with the translation of the word 'nurture' into what a felt sense of this would be as she struggled with "*not knowing what nurturing feels like."*

For Laura, the discussion around nurture was the stimulus for action:

> *"I'm going to go and find myself nurture and I'm going to find somebody and I'm just gonna keep going with it and not lose faith because I'm worth it."* (Laura, Week 13).

### 6.2.2 Understanding and accepting the child part of me

The connection to a child part of ourselves who has unmet needs was a major discussion in Phase Three. The women found the Janina Fisher model of neurobiological response to trauma (Fisher, 2017) which incorporates the 'fragmented parts' of us (introduced in session 9) helpful to make sense of their subjective experiences.:

> *"It's having the ability to nurture that child within you with the stuff that it never got when it was younger. So I think it's nurturing, maybe that's the missing loop, the nurturing that you might need to get for your child or can develop as a child."* (Freya, Week 13).

This articulation of their felt sense also opened up the possibility of acceptance and empathy towards the child part and providing the parental soothing that perhaps was lacking or, at the time, the traumatised child was not able to internalise. Freya spoke of becoming her own role model, catching herself when she begins to feel that she has made a mistake and starts to self-condemn:

> *"Instead of turning round saying to yourself "OMG I hate myself", or "I feel guilty about doing something" like that it's sort of like 'yeah, I did that. But I still love myself for it' and by training yourself to do that you're almost helping your little child to like realise that it's an okay thing, that it's okay to be who you are."* (Freya, Week 13)

The framing of feelings and actions coming from a much younger part of our self seemed to give a way of understanding and allowing perhaps more extreme and difficult to hold emotions. it also appeared to trigger a mothering / nurturing side of the women that they turned towards themselves. Here, Sally used the adult part of herself to notice a child's part and demonstrated kindness and compassion towards it:

> *"Me recognising that the child in me having a childlike reaction to what's going on. I needed the permission to recognise this is what that child wants: to be mothered, wanting to be nurtured and reacting like a child's might 'whoops! That's fine child, that's fine.' Now I need to turn into something else."* (Sally, Week 13).

The group afforded the opportunity to be vulnerable with others and I wonder if the same could be possible within a therapeutic dyad where there is an inherent power imbalance (see 7.3). The organic emergence of this discussion created something which was owned by the women which perhaps would have been lost or at least different if this was a scheduled topic as part of a manualised programme introduced by a facilitator.

### 6.2.3 From doing to being

The session which incorporated some mindfulness practices had a mixed response and each co-researcher had the opportunity to express their own critical subjectivity without fear of judgement. Christina found it a useful way to allow her *"something that was just for me"* while Freya noticed that for her it *"drains me of the negative stuff it just kind of let it all go rather than holding onto that"*. Another woman, who has been diagnosed with ADHD, struggled to maintain attention and opted out of the practices.

Sally wrote to me afterwards expressing *'something potentially quality of life changing'* about mindfulness. After just three practices within the group she noticed how physically drained she felt as her body *'went into complete rest mode'*; something she never experiences as she recognised that she is in constant *'threat mode'*. This, she realised requires adrenalin to *'keep going'* as poor sleep patterns deplete her of restful sleep.

In discussion Sally also spoke to the group of her realisation:

> *"Switching my head off allowed my body to do what it needs to do because I don't sleep very well and it's because my head is hypervigilant and always looking out for the dangers. I've got find a way to stop my head trying to protect me all the time, because actually it's not."* (Sally, Week 12).

As with all theories / models introduced, mindfulness was offered as something to try, with no expectation of any outcome. This positioning of 'holding lightly' removed the supposition that it 'should' be experienced in any particular way, with the inevitable perception of failure if it did not. The women were able to express an interest in further mindfulness sessions if they were interested. This is in contrast to the scheduled sessions of mindfulness included within ACT or DBT irrespective of how it is received by the individual. For some, perhaps, this would be reminiscent of school days where a prescribed curriculum is followed, alienating

some whose attention is lost when information seems personally irrelevant or too difficult to grasp.

### 6.2.4 Altruism

The women's desire to share their insight into self-compassion was harnessed in Phase Three during the all-day session when they planned who would author the newsletters and the content of them.

> *"If we make a difference even with one person, we've done our job, I feel. It makes difference to 1000 people then brilliant but one person, who hasn't been in this group, who hasn't known what we've been doing, if we can touch somebody like that even if it's one of the people in the office, or a counsellor who works here."* (Freya, Week 12).

Discussions around this broadened to one women being motivated to start a Service Users Network or SUN group, which would be run by Service Users for Service Users (see section 6.7).

## 6.3 What are the barriers to developing self-compassion?

| **Phase 3: What are the barriers to self-compassion?** |
|---|
| Greater understanding of barriers |

Table 15: Theme from barriers to self-compassion.

Table 15 shows just one theme in the barriers to self-compassion in this phase.

### 6.3.1 Greater understanding of barriers

Attention was given in Phase Three to reflect and consolidate what had been learned with an impetus for action and discussion around communicating to other service users via the newsletters. It is therefore not surprising that there was a tendency to focus on what had been helpful and positive in the research rather than continued discussion around barriers to self-compassion. This last phase therefore captured the women's own recognition and articulation of their barriers to self-compassion and this in itself transformed them into what was *helpful* in mitigating feelings of self-worth, isolation and self-criticism (Research Question number 1). The barriers remained and there was no symptom removal, instead the control / agency identified as lacking in Phase One was experienced through the women being able to understand and, to some extent accept, their own ways of being in relationship to others, and most importantly, to themselves (Spinelli, 2006). This theme of greater understanding of barriers is shown in Table 15 and following examples therefore could have

put in the ‘helpful’ section but, after thought, I decided to keep it within the ‘barriers’ section to emphasise the changing relationship the women had to their trauma responses and to serve as a contrast to the barrier sections in the previous two phases.

For example, Christina spoke about realising that her automatic response to any conflict is to worry that it is her fault and to ‘make it her issue’. Taking some time in our mindfulness session to reflect on her habitual responses and what she needs, was a ‘choice-point’ for a different behavioural response:

> *“When I got really upset when I was doing the mindfulness, but I really liked it because I think it really taught me that I need is to, when I feel like that, do something for myself. It could be totally unrelated but it’s like, today I’m going to see my friend who is in uni and it’s just like pushing myself to do something purely for me, not thinking I could see my boyfriend, or I could have done this… because it’s something I want to do and I’m happy that I’m doing it. So yeah, it’s helped me be more self-loving in a way.”* (Christina, Week 12).

Freya talked about realising her biggest barrier had been her own feelings of not being *“worthy or good enough”* for compassion and that *“not seeing the point”* and this was something that had changed for her during the course of the research.

> For the other women, they still struggled with self-compassion but spoke of a different way of recognising and relating to their self-judgement. At the end of the research I sent all the women a transcript of the introduction they made of themselves in the first session. Here is Jade again, who began the group feeling *“worthless”* and *“no good at anything”* in written response to a question at the end about whether she has shifted at all in the way that she sees herself:
>
> > *‘I feel that I have become more accepting of the way other people see me now. However I do still see myself in a negative way and although still difficult to take on the positives, I am able to ‘sit with this’ more than before. I think this will take a long time to overcome though, but I guess subtle changes are a good start. It’s taken a long time but I do actually now see myself as valued by the group, and I think that’s because I feel accepted and understood and people do want to listen. I don’t feel as though I have to apologise for being me anymore. I have also come to realise that although we have all experienced trauma when we were young, our circumstances were all different albeit quite similar and no one can judge exactly how we feel except ourselves and each of us (including me) just dealt with things in the only way we could.’* (Jade, post course correspondence).

I have purposefully not edited her words as I did not want to decide on her behalf what was less valid in order to remove it. It would undermine the complexity of trauma to suggest that fourteen weeks of a research group 'removed' the barriers to self-compassion but Jade's reflection captured her deepening self-understanding and acceptance of herself which removes the need for self-condemnation.

Sally also wrote to me after reading her initial introduction and narrative around her self *("I don't have self-compassion because I don't have a self. My self was taken away").*

> *'In terms of my "lost self" I am not sure that I could as far as to say that I feel I have a self. I certainly see there is a me but not sure I can yet say I feel her. I beginning to recognise that I need to live my life differently. That I do indeed need to look after me and that this is important. That I do have feelings and needs and that this is nothing to be frightened of. So I could probably say I can sense my self making clear demands for compassion. My ability to hear those demands is growing but I can still turn off my listening skills more often that I should.'* (Sally, post course correspondence).

Sally has lived several decades dealing with the psychological impact of her sustained childhood trauma so her measured and gentle steps towards a different way of being seem a fitting and wise response.

## 6.4 What is the role of the relationship with the group in developing self-compassion?

| **Phase 3: What is the role of the relationship with the group in developing self-compassion?** |
|---|
| Feeling accepted and the importance of shared experience<br>Reflected in the eyes of another |

*Table 16: what is the role of relationship with the group in developing self-compassion?*

Table 16 shows two themes around the role of the group in developing self-compassion.

### 6.4.1 Feeling accepted and the importance of a shared experience

The methodology of action research allowed the opportunity to reflect throughout the research upon the process of researching as part of a group so that the women could use critical intersubjectivity regarding any psychological benefits they felt from the project. The

aspect of unconditional acceptance was spoken about a lot by all the women, with emphasis given to the importance of being among women with a shared experience:

> *"I think the biggest thing here is no judgement. Nobody in this room judges anybody. Everyone has similar experiences, feelings and understand."* (Rose, Week 13).

Sally was able to reflect on why the shared experience helped her to be more open, experiencing the others as *"more trustworthy, because they also have that guard".* (Sally, Week 13).

Jade's comment hinted perhaps that a more common feeling state for her was of hypervigilance when she spoke of security and safety, which, as Rothschild counsels, is the foundation for all trauma work (Rothschild, 2010):

> *"you don't have to protect yourself with the group.*" (Jade, Week 13)

while Rose recognised the commonality of experience and the impact that had on her:

> *"I don't beat myself up because what I am feeling is normal here"* (Rose, Week 12).

This feeling of acceptance had a positive impact on other therapeutic relationships (the third contribution objectives for the research, see section 1.3).
For example, Freya admitted that she spoke to the group first, gauged their response and then felt more comfortable discussing the same issue with her counsellor:

> *"and it's been so much easier to talk about things as I felt acceptance here"* (Freya, Week 14).

### 6.4.2 Reflected in the eyes of another

In the first session the women expressed their self-judgement; defining themselves globally as *"completely inadequate"* or *"not good at anything"* and over the weeks and months had experienced being met with unconditional acceptance and validation. The judgement they meted out on themselves was countered by no judgement, the coldness they showed to themselves met with warmth. Small steps had been taken to test out perceptions of self and evidence of self-compassion beginning to be noted. The weeks of such positive relational interactions helped them to see themselves beyond their own judgement and instead as a 'reflection of the eyes of another' (Cooley, 1983):

> *"Letting other people maybe past the Iron Curtain, in a little bit, and thinking 'oh! They seem to quite like me!' (laughter from group). Yeah, but you have to go through the*

*thought process of 'oh!' (laughter from group) 'well maybe I'm not so bad after all!'"* (Sally, Week 12).

*"Knowing that, if someone else, likes me for who I am, from where I've come from and what happened, they don't even have to know the ins and outs, but they… there must be something about me that is likeable."* (Freya, Week 12)

In Phase Three, fifteen weeks after the research started, there were signs that the women were moving from a position of epistemic mistrust, noted in earlier weeks, to epistemic trust, where the motives of the communicator were accepted as relevant and believable (Bateman & Fonagy, 2016). This openness to another's mind allowed the possibility to hear and internalize positive social information that was created within the group, with the hope that this could be generalized to the women's wider social context (Bateman & Fonagy, ibid):

*"Talking to people in the group about my situation and giving myself permission to listen to people I admire, I can actually start taking in their words and, for the first time, I can start seeing what perhaps I should have been seeing all along." ( Laura: Week 13)*

### 6.5 Follow up and reflections two months later

| **Week '14': Follow up and reflections** | |
|---|---|
| Self-acceptance | It's not my fault<br>Not knowing the details but sharing the same emotions.<br>'Being seen' |
| On reassurance | Being nice. Not being able to 'hold' neg affect<br>Connecting brain and body<br>Starting with others to be able to turn it inwards |
| Examples of greater self-compassion | Doing something for me |

*Table 17. Themes from the 'follow up' session two months later.*

Eight weeks after our last group session the women had asked to meet again to check in with each other and discuss actions going forward. This also gave an opportunity to reflect with some distance on the experience of being in the group and consolidate understanding.

Table 17 shows the three main themes which arose from this session: self-acceptance, reassurance and examples of greater self-compassion.

### 6.5.1 Self-acceptance

A major theme in the discussion was the level of self-acceptance that comes from witnessing a commonality of emotions and the bonds which arise from that. Feelings of isolation were reduced as was captured by the women's own identification around their chosen nomenclature of #wearenotalone.

> *"The thing that we've all had the same is our emotions, our feelings. And it's not about what happened, we've all felt shame , or we all feel shame. At some point we've all felt guilt. We all feel petrified about certain things, like men or what happens, or not knowing, sexuality, whatever, we all have similar outcomes of it and I think that's where the commonality happens, It's not about what's gone on. It's about how we're dealing with it now."* (Freya, Week 14).

Most impactful though was the realisation that their emotions and responses were understandable and not something 'wrong' with them, which changed the response to self from one of condemnation to one of acceptance and even, perhaps, self-compassion.

> *"Commonality for me is… not hearing about the shame and guilt, it's about acknowledging that somebody else has the same struggles and then it's not about my personality or my choice. It's not predictive behaviour, but instinctive, it's survival behaviour and it's about being able to address that in a compassionate environment."* (Rhonda, Week 14).

> *"It's not that something's wrong with you because you feel that way, because it's not."* (Jade, Week 14).

For Sally, using the group as a 'test bed' meant that she could now start to generalise her learning into a wider context:

> *"There is something that has come out of the group about showing ourselves a little bit. I've been seen here and in this group and being seen perhaps about some of the things that, for me, I find really difficult, or we find really difficult, it might be about shame but, hey, the world is not collapsed. So maybe, I can go back out in the world and perhaps be a little bit freer about some of the things that are about me." (Sally, Week 14).*

### 6.5.2 On reassurance.

Throughout the research, reassurance seemed to play a key role and seemed to change as the process went on from a position of 'please don't feel that way' to more of a 'sitting alongside' respect for another's perspective. This become more noticeable during the writing up phase and session 14 presented an opportunity to share this with the co-researchers to better understand their perspective.

For one co-researcher, her reassurance was about reflecting back difficult emotions which she felt unable to contain herself:

> *"I want to be seen as a nice person but a part of me 'if I take it and don't reassure then I'm taking on that person's stuff . and I can't get rid of it. So to be able to reassure, I get rid of it. I don't want them to feel the same way as I do and because I'm an 'empath' I can feel when things are 'high' if there's a really high emotion in the room, it affects me so for me to be able to get rid of that, I either go really, really cold or try to reassure it. Realising that it's not a good thing."* (Freya, Week 14).

For others in the group it was the connection between recognising an emotional response in another which was so familiar to themselves, feeling empathy for it and being able to articulate it. That process of compassion to another could be then internalised as compassion to themselves:

> *"The fact that somebody else has said something about how they're feeling and whilst I'm saying 'I get it' and I'm being sympathetic, empathetic and everything else' there's something in my brain which is pure relief; an affirmation that I'm okay. I have to say it out loud because I have to hear it.* The saying or feeling is doing something bodily."(Sally, Week 14)
>
> *"I really mean everything I say but I'm also reflecting it to myself, and feeling it, and hearing me say it."* (Rhonda, Week 14)
>
> *"…then you give the reassurance, and I think it makes you then think 'actually, it's okay that I feel that way or it's not wrong that I feel that way because they feel exactly the same way."* (Jade, Week 14).

This deeper understanding of themselves, stimulated from a felt sense of empathy and connection to others might be understood from recent developments in human neuroimaging studies and the work around mirror neurons. The technical and ethical constraints surrounding the manipulation of neuronal activity in humans can only take our understanding of this area so far and there is still disagreement even around the definition of the word 'empathy' (Knapska & Meyza, 2018). Understanding so far seems to have concentrated on

the virtuous cycle of the consoler's 'warm glow' being the motivator for more displays of empathy and pro-social behaviour (Andreoni, 1990). The emotional resonance of empathy as a self-healing factor seems relatively under-explored and would be interesting as a separate research topic.

### 6.5.3 Examples of greater self-compassion

In Phase Three the women continued to speak of noticing gestures of self-compassion, (the first contribution objectives for the research, see section 2.7).
Christina noticed that she was actively arranging more things which she found enjoyable. This was echoed by Rose:

> *"I've always been there to help someone else and I don't mind. I've always wanted to do it but I think that I've realised in the last few weeks that I actually need that for me. I need to focus on me which I think is self-compassion. I am actually finally taking some time for me, thinking about me and what do I need?"* (Rose, Week 12).

Freya spoke about making a choice to change her behaviour, also showing the cognitive learning she had made. She realised that she had been triggered when asked for her birth certificate at work:

> *"Never before would I've said is that that it was a trigger because I would never have known. And then going out and having a smoke, which is not something I would normally do at the time. Calming myself down."* (Freya, Week 12).

## 6.6 Planning what next - Energy around action

The action part of the research was the area I was most concerned about before the research began with fears that the co-researchers would not be motivated or have the time to commit to anything outside of the group. For me, as a Psychotherapist, I was hopeful that the group would be helpful for the individuals within it but I felt the pressure of the expectation that an action research approach holds the intention that 'knowledge is formed for action, not reflection' (Reason, 1988, p.12). The group planned a series of ten newsletters to service users of the agency. These were mostly psych-educational, for example: The impact of trauma on the body and brain, Learning soothing, Compassion, Boundaries and Assertiveness. All women agreed to contribute, sometimes writing with another, and Jade converted all text to a newsletter format (see Appendix 11 for an example).

Another outcome from the group was a desire to connect with other service users via a Service User's Network. Sally met with the Director of the Agency with a proposal covering fundraising events and opportunities for service users to connect for example through drop in coffee sessions. She was also keen to draw upon the talents of women service users to create a pool of skills for example help with CV writing or developing interview skills. Jade, encouraged by the responses to her newsletter, volunteered to re-design the agency website which would develop her skills and help her to build her own CV.

All of these outcomes gave something back to the Agency, helped other women who were involved with the centre as service users but also gave the women the experience of being valued, respected and a part of a community, highlighted by Yalom & Leszcz (2005) as important for psychological well-being. This action as an outcome of the research is also, of course, a vital part of action research where it is considered that 'theory without action is meaningless' (Reason & Bradbury, 2001, p.2) and provided the vehicle for sharing knowledge more widely about 'what works' (the second contribution objectives for the research, see section 1.3). Reflections on action research as a methodology will be explored further in the discussion.

### 6.7 Summary of findings and answering the research questions

This research started with three research questions:

1. What approaches do they find helpful, if any, to help mitigate self-criticism, feelings of low self-worth and isolation associated with shame?

2. What are the barriers to developing self-compassion and can they be overcome?

3. Given that sexual abuse is an interpersonal trauma, what is the role of the relationship with the group in developing self-compassion?

Table 18 shows my summary of the three phases of the research. Phase One is dominated by negative impact of trauma in the intra-psychic realm and includes the experience of a damaged sense of self and self condemnation. This first phase of the research therefore focussed on the second research question around the barriers to self-compassion. The manifestation of trauma in physiological responses was spoken about by all of the women, resulting in feeling out of control and the secondary suffering of self-condemning judgement on their inability to cope. Their challenges also extended to the inter-psychic impact on relationships such as a lack of trust in others or difficulties in understanding or holding boundaries. When the women started the research they all spoke of these challenges as

barriers to self-compassion with noted surprise that their own feelings were echoed by others in the group. The natural tendency to isolate after the shame-based trauma of CSA (Talbot, 1996) meant that their experiences had not been shared, precluding them from testing out their own perceptions of self and others.

By Phase Two the group was demonstrating a cohesive bond and the women were talking of a felt sense of acceptance and belonging. The third research question, which was the importance of relationship in the group, started becoming more into focus. This provided the stability and solid foundation for deeper discussions around personal challenges experienced in boundary setting, assertive behaviour and trust within interpersonal relationships. The coping strategies learned in session five of Phase One were being explored with learning from the psycho-educational session on trauma giving them insight into their sometimes confusing responses to life events. Additional information sent between sessions was provided in the spirit of 'explore if interested' with no pressure to attend to it (conversations in sessions suggested that some were following up on this with encouragement for other group members to read or watch particularly interesting courses of extra information). These individual elements within a framework of action research put agency at the front, back and centre of the research; the group members decided what topics to pursue, agreed together and then managed the boundaries of the sessions such as timekeeping and keeping on topic and suggested their own journal question for reflection over the week. The process therefore of the research approach in itself gave an experience of personal efficacy which, in the context of a 'holding' group, gave the women a safe space in which to develop their own critical subjectivity, gaining greater understanding and acceptance of themselves answering research question 1: what is helpful in developing self-compassion.

Phase Three was an opportunity for consolidation and planning. It was interesting that we didn't refer back to the framework in Phase Three, as if we needed a framework earlier in the research but then didn't want to be constrained by it. Phase Three felt a movement away from conceptualising and classifying (propositional knowing) and towards the felt experience of belonging to the group, of shared meanings at relational depth (experiential and positional knowing). The women spoke of a felt sense of acceptance from others in the group and how this was paralleled in a developing acceptance and compassion of themselves: the first of the 'contribution' objectives for the research, (see section 2.7) and answering Research Questions one and three. Phase Three also harnessed the intrinsic need to feel that one has something to contribute to society (Yalom & Leszcz, 2005) with plans for communicating what had been learned to inside and beyond the agency. This therefore both benefitted the co-researchers and also satisfied the requirements of the methodology which considers

action towards ‘a better, freer world’ as the purpose of action research (Reason & Bradbury, 2001, p.2) and the second contribution objectives for the research, that of disseminating findings.

The approach of action research provided an enabling and transparent environment in which to collectively be curious about internal processes. This, when practiced with non-judgement, allowed the opportunity to accept oneself with compassion: Research Questions one and three. The collective approach was also helpful for me; I did not have to struggle with this alone and ‘interpret’ another’s experiences. I was able to take to the group my thoughts and together we tried to understand what was happening, for example, the function of reassurance for both the reassured and the one giving the reassurance. This approach was consistent with the subjective-objective ontology (Heron & Reason, 1997) behind the methodology and the belief that individuals have the capacity to give meaning to their own experiences (Reason, 1988).

| | | | |
|---|---|---|---|
| ACTION RESEARCH: A FLATTERED HIERARCHY WHERE MY VOICE IS SOUGHT AND MATTERS (GAINING AGENCY)<br>I CAN MAKE A DIFFERENCE (altruism)<br>Therapeutic group: a safe space where I am accepted | Phase 1 | **PHASE 1**<br>**RESEARCH QUESTION 2: BARRIERS TO SC**<br><br>**STABILISATION:RE-GAINING CONTROL**<br>**Starting from a position of isolation, self-condemnation and experiential avoidance**<br>The felt impact of trauma<br>Emotional detaching / experiential avoidance<br>Self-judgment<br>No sense of self<br>Lack of trust – in others and self<br>Boundaries (problems with)<br>Feelings of worthlessness | **Well researched and documented impact of relational trauma: lack of agency (control), thwarted sense of self. Experienced in isolation with a tendency to withdraw from others.** |
| | Phase 2 | **PHASE 2**<br>**RESEARCH QUESTION 1: WHAT IS HELPFUL IN DEVELOPING SELF-COMPASSION?**<br><br>**A DEVELOPING SENSE OF SELF-RESPECT AND ACCEPTANCE OF MYSELF.**<br>Understanding myself: the impact of trauma on my sense of trust, boundaries and levels of agency (including assertiveness).<br><br>**THE RELATIONAL IMPACT OF DOING THIS IN A GROUP: RESEARCH QUESTION 3.**<br>A felt sense of acceptance from others and belonging<br>A sense of common humanity: I, and everyone else, is human and fallible (trust)<br>A bi-directional felt sense of empathy: felt empathy for you becomes felt empathy for me | **Satisfying the psychological need for agency (increasing self-respect).**<br>**The need to belong and feel accepted.**<br>**Felt and demonstrated empathy for others and self.** |
| | Phase 3 | **PHASE 3**<br>**UNDERSTANDING & ACCEPTANCE OF MYSELF: RESEARCH QUESTION 1.**<br><br>**RELATIONAL ASPECT: RESEARCH QUESTION 3**<br><br>I belong<br>I am accepted<br>I have something of worth to give others (altruism) | **Psychological need to feel a part of a community and that one has something to contribute. A felt sense of acceptance from others and to myself.** |

Table 18: Summary of phases.

# CHAPTER 7: OVERALL DISCUSSION

## 7.1 Introduction – the challenge of self-compassion

This research looked at the challenges around feelings of self-compassion for women who have been sexually abused as children. My motivation for this originated in my own clinical experience of working with this client group and hearing them speak with self-condemnation which covered every part of their lives, carrying with them the shame not of what they have done but, in their eyes, of who they *are* (Bromberg, 2011). Action research was chosen as I reject the notion of deciding, on behalf of the women, what intervention might be of interest to them, facilitating instead empowerment and agency with respect of their decisions, where their wishes and agency have been overruled in the past. With a common bond of relational trauma between the co-researchers, if change happens through implicit relational knowing (Boston Change Study Group, 1998), I was interested in understanding more about the role of relationships within a group during research around self-compassion.

The interest in compassion within psychological interventions has grown alongside interest in other contemplative approaches to the self. Within psychology, emphasis has moved from challenging cognition to ways in which we can relate to our thoughts and acceptance of emotions e.g. ACT (Hayes, Strosahl & Wilson, 1999), DBT (Linehan, 1993) and Mindfulness (Segal, Williams & Teasdale, 2013). However, although the psychological benefits of an increase in self-compassion are well documented (e.g. Neff, Kirkpatrick & Rude, 2007), Gilbert et al, 2008), it has also been found that a subjective fear of compassion can be a learnt way of being in the world as a result of experiences in relationship *with another* i.e. a felt reality of meaning was constructed through relationships. It is my argument that the damage that was done in relationship can only be effectively healed in relationship but I question whether the most efficacious way of facilitating this is through individual therapy sessions alone. Such is the long shadow of CSA; the isolation of suffering borne alone, the lack of validation for the suffering and fear, the absence of an internalised protective and loving internal object to contain or soothe distress, that it is a monumental challenge to rebuild this sense of safety with others, and ultimately with oneself, through a therapeutic dyad alone.

Adding to this challenge is the correlation between a fear of compassion *for* the self and a fear of compassion *from* others (Gilbert, 2014b). This resonated with my own clinical experience of CSA clients showing resistance to any form of empathy shown towards them and highlights the Herculean task of using a one hour weekly session with a therapist to repair the relational damage done possibly decades ago. All of the women in the research group had been, or were currently in counselling but, despite the empathy and compassion

shown to them, this was not somehow *felt* and translated into any form of compassion for themselves. Therefore, although both the benefits of self-compassion on mental health are clear and the difficulties in engaging with the concept for those who are fearful of it are known, we are still learning how to therapeutically manage this. This research explored a different 'no intervention' intervention approach which will now be discussed. A discussion around the benefits of doing this in a group context, rather than a therapeutic dyad, will follow in section 7.3.

### 7.2 The 'no intervention' intervention

Current approaches to developing self-compassion generally rely on an 'intervention', for example, developing self-compassion through self-soothing techniques (Gilbert, 2010; Germer & Neff, 2015) or explicit attention on the 'here and now' internal experience of sensorimotor psychotherapy (Ogden, 2015). Given the challenges of engaging with self-compassion when past traumatic relational experiences have resulted in shame-based self-condemnation, this research sought a different way to explore this challenging problem. No 'solution-focussed' intervention was brought to the women, they were asked only to explore together with peers a topic they mutually struggled with: self-compassion. This resulted in the relational element being centre stage of the research, and with the approach of action research, the *process* itself superseding the *content* of the sessions.

Essential in this, I believe, was the flattered hierarchy of action research. When one person in the therapeutic dyad or running a group holds the power of bringing a pre-formed idea of a solution, whether it be a specific psychological theory / model or a prescribed manualised approach of a course, it carries an expectation of results. Indeed, in our enthusiasm for evidence-based practice and measurable outcomes, we place emphasis on this; but to what impact on the individuals who are the recipients? The expectation of an outcome holds the implicit message that when they begin the intervention they are 'wrong' in some way, that they can 'be better' than they already are, rather than developing understanding and acceptance for who they are.

For example, I could have chosen an approach such as CFT. I completely agree with the tenets of CFT and admire Gilbert's interweaving of evolutionary psychology, Eastern philosophy and neuro-science which has brought a new approach to therapy (Gilbert, 2010). However, I wonder if the approach of psycho-education and exercises specifically designed to encourage the development of self-compassion was, for this client group, possibly creating a funnel for their self-criticism; it seemed a way of creating the supposition that if the women were able to understand the theory and 'do' the exercises correctly, they would be

able to be more compassionate to themselves and even ‘feel better’. And if they did not connect with the intervention, it created the possibility of this being internalised as their own failure. In addition, the concept of ‘feeling better’ suggests that change is needed, that they are somehow ‘wrong’ as they are, which is in direct contrast to acceptance. Mindful of the paradox of change (Rogers, 1967), which suggests that change only happens when one is not trying to make it happen, the approach of researching this together removed the expectation and implicit pressure to change.

As an alternative approach, within the parameters of action research we were able to explore together various models and theories, including the concepts of Compassion Focussed Therapy. However, as with all models / theories, it was held lightly, and the women utilised what was useful to them personally and left behind what did not resonate. This was consistent with a relativist epistemology which rejects the concept of a reality to bring understanding and instead invites a perspective of multiple truths, making the whole research both theoretically and practically congruent.

The ‘exploring together’ approach also avoided the ‘doer done-to’ (Benjamin, 2004) dynamic in which I could be construed as the one with the answer/s, creating a knowledge and power differential in my relationship to them, a re-enactment of the power differential they experienced during sexual abuse. Participation was therefore not used as a technique (Reason & Bradbury, 2008) but as a value-driven way of repairing the damage done in childhood when no-one asked the women what they wanted and no-one listened or valued their opinion. Indeed, just the ‘formation of communicative space’ in an action research project is a form of action (Kemmis, 2001, p100) and is laden with the explicit message that their opinion as experts by experience, was sought, valued and could be helpful; an entirely different position from them being passive participants of an intervention. They were invited to research a difficult topic which, so far, has challenged both client and therapists alike; how to work with a condemning self-concept.

Starting the research process from this question and valuing their contribution, set the conditions for empowerment and the hope / belief that they could, in the group, work on something meaningful. The belief in personal efficacy was therefore engaged, which held the possibility of moving from a position of being mere onlookers of their own behaviour to actively contributing to their life (Bandura, 2006) and, arguably, also contributing to others. The empowerment coming from taking control was then echoed in the research itself, with discussions around this in Phase Two (for example, see section 5.2.1) on taking control by informing the police or stating clearly ‘that was not right’ to the abuser.

A sense of bonding and optimism was palpable from the first session; the expressed feeling that something could be achieved in the group that would be positive, even if, at that point, it was unclear what that would be. The 'instillation of hope', one of the 11 'therapeutic factors' in groups (Yalom & Leszcz, 2005, p.4) was therefore present from the beginning, and this hope of doing something positive with their experiences to help others, continued to be a thread throughout the research.

### 7.3 The importance of the group – creating an intersubjective space

I have remarked above on the enormous task of repairing the damage inflicted in CSA within a therapeutic dyad alone. Despite any intention that the therapist's approach or theoretical model may aspire to in creating a 'shared third' rather than 'doer done-to dynamic' (Benjamin, 2004, p.), there is the undeniable frame of the helper / helped: one person seeks the help of the other who, by privilege of training, is assumed to be able to do so. Irrespective of the focus on content or process, whether it is psycho-education, interpretation of transferences or sitting with, this power imbalance is present; a co-created subject-object is created (Ogden, 1994). While one person within the dyad is struggling, and perhaps expressing, a sense of unworthiness, self-loathing and condemnation (as voiced by the co-researchers in session one), the other (therapist) would not be expressing the same (judicial use of disclosure as a therapeutic tool aside). Therefore, this power balance is heightened and re-enacted; disclosures by the client reinforce the sense of difference and inadequacy when compared to the person sitting opposite them.

This was entirely different in a group of women with the same trauma histories where multiple disclosures of affect were made. Whereas, within a therapeutic dyad, the therapist represents 'all others' in the client's world whilst, simultaneously 'the exception to the rule' (Spinelli, 1997, p.111), our group of eight represented a wider collective which represented more than the sum of its parts. Multiple therapeutic alliances were therefore available rather than one in a dyad (Kivlighan & Kivlighan, 2016) the quality of which, has been suggested, is related to individual change as a therapeutic outcome (Yalom & Leszcz, 2005). The acceptance that they denied themselves was given without hesitation from the rest of the group from their subjective experience of feeling the same. Interestingly, while the realisation of shared struggles could have been dispiriting, actually there was laughter and joyful pleasure in the discovery of sameness and kinship. This, in itself, framed the experience in a different way.

The group was set up with an intention of creating a safe, intersubjective space. As an Integrative Psychotherapist, the style and culture of the group was informed by my training at Metanoia and some experience of working with a therapeutic community style group in the NHS. The intention was not to set up group therapy as this would have been incongruent with action research; any self-assigned role of therapist or group facilitator would have created a different dynamic within the group than the flattened hierarchy of co-researchers that defined us all (whilst acknowledging that we all had different skills to bring). However, the group was, without doubt, therapeutic.

Where the women had felt the absence in the past of a safe, holding other, it was vital that this was created before any work on self-compassion could begin. A therapeutic space providing safety, confidentiality and, at all times, the modelling of unconditional personal regard (Rogers, 1967) was created.

The section on 'Decisions of how to work together' provides the detail of what was *done* but what is more difficult to portray is the *felt sense* of the intersubjective space that was created. This was 'learning it from the inside out', a 'bottom up' process as much as sharing cognitive understanding. Whilst our left brains engaged with the narratives around self-compassion, our right brains monitored the unspoken, implicit messages that lay 'between the lines' (Stern, 2004, p.114). An opportunity to experience a different relational dynamic was central in the process. Although some women contributed more verbally than others, this represented just one element of the research and the comments from the follow up session show that the impact of feeling met and accepted in a group was as important, if not more so, than intellectual knowing. Again, this feeling of acceptance by multiple others would have been absent in a therapeutic dyad and, I believe, was central to the outcomes of the research.

The group also arguably provided the opportunity to encounter the five 'necessary experiences' for 'good enough' emotional development: attachment, containment, communication, inclusion and agency (for a fuller explanation of these see Haigh, 2013, p.49). When any of these are thwarted, by neglect, illness or abuse, lifelong consequences are likely to occur (Pearce & Haigh, 2017). All elements were served well from being in a group. 'Communication' extended beyond a talking therapy to a sense of kinship from the company of ones who understood and accepted. 'Inclusion' countered isolation whether it was physical or emotional which would have been a challenge in a dyad and 'agency' was encouraged in their roles of co-researchers. The opportunity for 'attachment' to, not one but several others, was a playground for testing assumptions and experimenting with other behaviour. The 'containment' within the group was essential as the milieu to support each of

these elements and allow an opportunity for flourishing. As mentioned by one of the women in a session, a ‘win’ for one was felt by all, as the therapeutic gains of one was observed and felt by another. Both of these points will be discussed at more length in section 7.5.2.

It has been suggested that the focus on the individual within personal therapy increases the opportunity for addressing intrapersonal goals such as problem solving. In contrast, a group may be more effective for interpersonal goals (Kivlighan & Kivlighan, 2016). Self-compassion, at first glance, would perhaps be defined as intrapersonal and therefore best served in a therapist-client dyad. However, I would suggest that when the condemning self is the experience and expression of shame following CSA, a relational trauma, the relational element within a group is a crucial factor in coming to a feeling of acceptance and worth. This is needed first to be felt from others in order for it to be experienced for the self. For six out of seven of the women, who were already in counselling, their own lack of self-compassion had not been helped within their therapy sessions hence their own self-selection for trying to meet this need in the research group.

Of course, some elements available to dyadic working were missing in a group setting. There was no explicit focus in the group on working through transference / counter-transference relationships, described as ‘one of the most potent form of changing relational patterns’ (Clarkson, 2003, p.82). For example, one woman could recognise that I became to represent to her the mother she always wanted which was the catalyst for feelings of neglect when not given ‘special’ attention within the group. This was raised and empathised with in private communication but not addressed in the group as time was limited and it was not the remit of our work together. This is the valuable area where individual therapy can optimise learning and personal growth. The co-researcher was encouraged to seek additional therapy once the group ended where focus could be given to her own relational process.

In other models of therapy such as DBT, a combination of group work and individual sessions delivered by the group facilitators gives the opportunity for reflection upon actual events or perceptions in the group. Therefore, the individual therapy supports and deepens the group work and this would have been beneficial for this group had I been working with another co-facilitator.

The research findings highlighted some elements which could be incorporated into one-to-one work. For example, all of the women spoke of the very helpful role of psycho-education in trauma which could be tailored to individual needs in a therapeutic dyad. The approach of acceptance and understanding rather than symptom removal or challenging thoughts is also transferable to individual client work. Perhaps most of all, creating a spirit of exploring alongside the client rather than holding oneself as the ‘expert’ who has interventions to ‘fix’ is

a way to incorporate the benefits of Action Research into individual work. However, I do believe, as argued throughout, that the group provided an essential part of developing self-compassion for this shame-based client group. The felt sense of acceptance from others who had shared the same experience ultimately became acceptance of themselves. This is not to denigrate individual therapy but to recognise that, as social beings, a felt sense of belongingness and social learning within a group of peers can act as 'specific drivers of change' (Pearce & Haigh, 2017, p.53) which is hard to create in a dyad.

The development of relationships with the group also brought its own challenges. If I was the symbolic 'mother' of the group, this dynamic perhaps created an opportunity for 'sibling rivalry'. I wonder how much they subconsciously wanted to please me in order to receive attention and praise and this might have manifested in positive remarks about the research creating a bias. In my modelling of being someone who could engage with self-compassion, did they strive to be like a fantasy of how they thought I was? This would be an impossible standard to live up to and it was inevitable perhaps that I would, sooner or later, disappoint (see 7.8.2). I was very careful about containing any additional individual contact with me outside of the sessions to avoid any perception of favouritism. I was 'outside' of the group chats so was not aware at the time of any tension but this did arise, I discovered, afterwards amongst the co-researchers around who would present at the National Conference (only three were invited plus me). Although not all wanted to go, I suspect all would have liked to be asked to go even if they did not present to the conference whilst there.

A number of the women already knew each other outside of the group from membership of another group in the agency. During the research the women discussed their difficulties with trust and boundaries so it was perhaps not surprising that these played out as they developed and deepened friendships. I was not aware at the time of the dynamics occurring 'off stage' with one or two of the women contacting another for support when they felt distress. With their need to please and difficulties in saying no, this was, at times, experienced as overwhelming and triggering and, ultimately, rejecting by the other. Perhaps, again, as the idealised mother whom they did not wish to disappoint, they did not make me aware of this and I did not pick up on any tension in our meetings. Had this been more openly discussed we could have explored how best to manage this difficult situation by perhaps saying no and re-directing to help elsewhere in a compassionate way that neither triggered rejection or resulted in guilt. I wonder if there could have been a greater emphasis on the ongoing negotiation of how the group worked together rather than perhaps a feeling that we had covered this in week one and it was set in stone. This area, I think again raises the tension in running a therapeutic group that was not group therapy where such things

would be expected to be aired and explored in the group. Should I run a group again I would include this as a topic to be discussed and included in group rules.

### 7.4 The alchemy of action research and a therapeutic group.

The similarities in intentions and philosophies of action research and therapeutic community principles in the context of a therapeutic group made them compatible bedfellows. For example, the principles of a therapeutic community situate the individual's experience at the heart of therapeutic care, as well as promoting agency through interdependence learned in the group (Pearce & Haigh, 2017) and both of these are congruent with the action research principles of researching *with* and *for* people rather than *on* people (Reason, 1998). In addition, therapeutic community principles define the 'specific drivers of change' (Pearce & Haigh, 2017, p.53) as belongingness, social learning, the promotion of responsible agency and narrative development. These are arguably all present within the framework of an action research approach and were noted in the 'Findings, analysis and preliminary' chapters.

I have discussed above the benefits of a therapeutic group over a dyad and the addition of action research with its own unique qualities created more than the sum of its parts. What is not usually included in a therapeutic group - but lie within the aims of action research - are the expected outcomes of 'actionability' and 'sustainability' (Quality Choice Points of action research 5 and 7, Bradbury (2014)). However, as noted in the 'Findings, Analysis and Preliminary Discussion' chapters, setting an intention of creating something that was useful to other women who had experienced CSA was both a motivation to join the group initially and one of the reasons, I believe, why there was no attrition during the research. This inherent psychological need to feel that one has something of value to give, facilitating a feeling of belonging, was articulated throughout the research, a way perhaps to try and salve the perception of shame over past trauma. Using the methodology of action research where 'knowledge is formed in and for action rather than in and for reflection' (Reason, 1988, p.12) was therefore the perfect approach to satisfy this need in a pro-social way, benefiting both the women in the group and potentially other women who they were able to connect with.

The action part was sustained after the group finished, continuing to give the women a sense of worthiness and contributing to sharing 'what works' (one of the 'contribution' objectives for the research, see section 1.3).

Three women presented their findings from the research at the agency's National Conference November 2017 and the group are now actively working on creating a Service User's Network (SUN) Group to connect with more service users. This essential part of action research brings something that is not usually included in therapeutic work but was key

in satisfying an inherent need for altruism, a feeling of having something useful to give (Yalom & Leszcz, 2005), bringing the psychological into action research.

### 7.5 Building on current understanding: Neff's Components of Self-Compassion

I was interested to apply the findings from this research to existing theory on self-compassion to potentially contribute and build on our current knowledgebase. Neff has identified three components of self-compassion: self-kindness, common humanity and mindfulness (Neff, 2003) and I used this frame work to further explore our own research questions of what were the barriers to developing self-compassion, what was helpful in developing self-compassion, and the role of the group.

In clinical work with non CSA clients they often admit that they have never *considered* self-compassion rather than the resistance and fear shown towards the concept which is referenced in the literature (Gilbert, 2010. This was articulated by this client group from the very first session. Neff and Germer also write of resistance to compassion, labelling it 'backdraft' (Germer & Neff, 2015, p.52) and it is hoped that this research contributes to the field of understanding in this difficult area.

If Neff's components show what is required to move towards self-compassion, this research explored the challenges of women who were not starting from an absence of those qualities but from a surfeit of trauma-driven opposites shown in Table 19: instead of self-kindness there was self-condemnation, in place of a connection with common humanity there was fear and distrust of others and rather than sitting with difficulty as taught in mindfulness, there was aversion / disassociation from affect. A movement was required therefore from a profound *deficit* of these qualities which was so apparent in our first session together before being able to engage with Neff's three components of self-compassion.

Each of Neff's three components will be discussed in turn, considering the particular difficulties for this group of women (summarising the barriers to self-compassion within the context of Neff's components Research Question no. 1) and what was found to be helpful in moving from the deficit position towards engagement with self-compassion (Research Question no. 2). Research Question 3 'What is the role of the relationship with the group in developing self-compassion?' is more fully discussed in section 7.5.2.

| MOVING FROM A POSITION OF DEFICIT FROM PAST TRAUMA | TOWARDS NEFF'S COMPONENTS OF SELF-COMPASSION |
|---|---|
| Self-condemnation, the internalized 'bad object' | Self kindness |

| | |
|---|---|
| Isolation, fear and mistrust of others | Common Humanity |
| Experiential avoidance; aversion and dissociation | Mindfulness |

*Table 19: Moving from a deficit position to one of self-compassion*

### 7.5.1 Self-kindness

| **Self-condemnation** | **Self-kindness** |
|---|---|
| The Impact of trauma Ph1, B | Doing something for me Ph1,H |
| Shame Ph1, B | Noticing moments of self-compassion, Ph2, R |
| Sense of self and self-judgement Ph1, B | Understanding & accepting the child part of me, Ph3, H |
| Secondary suffering, Ph1, B | Reflected in the eyes of another, Ph3,R |
| Shame, Ph2, B | Self-acceptance, Ph3 |
| | Examples of greater self-compassion, Ph3 |

*Table 20: Themes from the research in the context of Neff's 'self-kindness' component and its trauma driven opposite; self-condemnation.*

Key: Ph (phase); H (helpful), B (barrier), R (relationship)

Table 20 shows evidence from each of the phases of the self-condemnation which had to be first overcome before any self-kindness could be experienced. Note that most of these were discussed in phase one of the research. Further evidence of self-kindness is shown in the right-hand column. These were mostly expressed in phase three of the research, showing the developing nature of this element of self-compassion.

Neff defines this component as being kind and understanding of one's own failures or inadequacies (Neff, 2003; Germer & Neff, 2013; ). Self-kindness entails soothing and nurturing oneself rather than self-criticism.

Showing self-kindness was a particular problem for this client group and this was evidenced from the very first session. The themes summarised the barriers that the women in this group experienced to developing self-kindness and as they spoke of the impact trauma on their lives, their shame and secondary suffering. Despite their own attempts to distract from feelings of inadequacy, such is the insidious nature of self-condemnation that the women expressed not being worthy of anything other than their own 'pointed quills of guilt or judgement' (Faulds, 2003) and therefore did not feel able to move from this.

All bar one of the co-researchers had been receiving individual counselling, whether through the agency or privately but they still lived with persistent self-condemnation. This shows the pervasive nature of shame and the challenge of trauma schemas (section 5.2.2). Within my own client work I would often find myself challenged by this, resorting to challenging negative thoughts or aligning with one part of the client rather than embracing all parts, including the judgemental part.

This research offered a different way in which the women could better understand why they reacted as they did to life events. Most important in this was a psycho-educational session on the physiological responses to trauma that was held early on in the research, taking an evolutionary perspective to make sense of what can be seemingly senseless somatic responses (e.g. Rothschild, 2000; Gilbert, 2010; Fisher, 2017). None of the women in the group had ever been informed about this by their counsellors (most of whom were Person-Centred trained) and yet reported that this was one of the most helpful things they had learned throughout the research. This was useful learning for the centre and something that we plan to run a CPD workshop on for all volunteer counsellors to share understanding of 'what works' (one of the 'contribution' objectives for the research, see section 1.3).

Exploring these concepts together, not brought as absolute truths but as alternative ways of seeing themselves and how they relate to their worlds gave more scope to develop a more 'observing self' (Deikman, 1982) so that the women could better notice their trauma responses, understand them and ultimately accept them. 'Befriending all their parts' (Fisher, 2017, p.74) and *acceptance* of themselves was therefore a vital stage before self-compassion could be considered and one relatively unexplored in the three components defined by Neff (Neff, 2003) .

Acceptance removes the need for a negative response to what is thought or felt ('secondary suffering', mentioned in section 4.2.5) and links to the mindfulness concept of non-judgement. This stage creates a neutral position which does not need to trigger a fear of compassion response as there is not the underlying belief of unworthiness and a greater ability to recognise when they are 'consciously confused and unconsciously controlled (Gabbard, 2014). Doing this in a group played a large part to that acceptance and will be discussed more in the next section.

Understanding and acceptance can then take one from a deficit position to at least a neutral stance and prepares the ground for self-compassion. Again, arbitrary distinctions between Neff's components are misleading and the noticing how we respond, understanding why that

would be and acceptance of it can also be considered elements of mindfulness so all components are interrelated. Acceptance was not enough on its own however; acceptance without compassion could be experienced as ambivalence, without any warmth or empathy whereas acceptance with compassion holds each part of us 'lovingly inside' (Fisher, 2017, p.78).

The women's reflections around their need for nurturing was the additional step to self-compassion; a learned secure attachment where tenderness, empathy and love are both cognitively recognised but most importantly, emotionally felt. The role of others in achieving this was apparent from the first session, where there was a collective appreciation of being in the presence of others who knew their fears and their daily struggle to just be themselves. The additional element of seeing themselves reflected in the eyes of another was a major factor that the women identified as an opening to the possibility of a different way of relating to themselves and of moving from self-condemnation to self-kindness; finding a secure attachment within themselves.

### 7.5.2 Common Humanity

| **Isolation, fear and mistrust of others** | **Common Humanity** |
|---|---|
| Daring to connect, Ph1, R | Finding commonality & a sense of hope, Ph1,R |
| Relational Impact of trauma, Ph1,B | Seeking kinship / acceptance, Ph1, R |
| Shame, Ph1,B | Daring to connect, Ph1,R |
| Impact of developmental trauma, Ph2,B | Understanding others, Ph2,H |
| Relational schemas, P2,B | Acceptance and belonging, Ph2,R |
| Holding boundaries, Ph2,B | Expressing emotions and connecting with others, Ph2,R |
| Needing acceptance and wanting to please, Ph2,B | Learning from and with each other, Ph2,R |
| | Feeling accepted, Ph3,R |
| | Reflected in the eyes of another, Ph3,R |

*Table 21: Themes from the research in the context of Neff's 'common humanity' component and its trauma driven opposite; isolation, fear and mistrust of others.*
Key: Ph (phase); H (helpful), B (barrier), R (relationship)

Table 21 shows evidence from each of the phases of the isolation, fear and mistrust which were barriers to what Neff describes as common humanity. These were dominant themes in both Phase One and Phase Two of the research. Expressions of common humanity, as

experienced in the group, were spoken of from the very beginning of the research and were prevalent in every phase (shown in the right-hand column).

Neff defines ‘common humanity’ as recognising that imperfections and failures are normal and a common experience for all, and suffering is a natural human condition. This changes the perception of our own imperfections as being separating and isolating and differentiates self-compassion from self-pity, which is a more ego-centric ‘woe is me’ attitude (Neff, 2013, p.2).

The nature of CSA with the accompanying secrecy and shame is one of isolation and of difference. At its heart a relational trauma, it impacts on different relationships; the experience of powerlessness with the abuser (often mixed up with feelings of wanting to attach), the feeling of aloneness when the mother did not protect and the unspoken secret that is felt as holding the child / woman apart from others. All of which create a barrier of distrust, disappointment and difference of oneself to others that was articulated again and again by the women in the group: in their relationships with others, their trust of others’ especially men and their deep held belief that they were somehow lacking or wrong and different. The complete *absence* therefore of ‘common humanity’ and the opposite of isolation, fear, mistrust and difference were the barriers to self-compassion that stood in the way of self-kindness.

From all our understanding of intersubjectivity, developing connectedness does not come from left brain, cognitive understanding, but a *felt* sense of connection; ‘attunement and empathy are nonverbal somatic experiences’ Fisher, 2017, p.61). The opportunity to do this was provided within the group and the long list of themes around feelings of acceptance and of a sense of belonging was testament to importance of this theme. Where, in their past or everyday life, perceived inadequacies might have been felt but not shared or shared and dismissed (possibly with the intention of making someone ‘feel better’), here they found a space in which they could speak about their very human feelings, discover that they were not alone in their suffering and hear the common struggles but also successes of each other. This proved the instillation of hope; one of the 11 ‘therapeutic factors of change’ (Yalom & Leszcz, 2005, p.4).

The addition of action research also promoted the desire to reach out and connect with more women who had been sexually abused in childhood.

Whereas therapists might feel the pull to reassure in a bid to counter their own feelings of helplessness in the counter-transference (Herman, 1997), in this group their feelings were understood and validated. In the therapeutic dyad, even the most relationally attuned

therapist who might ‘sit with’ the feelings of the client would usually be coming from a place of difference, whereas in a group of peers, there was connection of likeness and an accepting-confirming mirroring was felt (Kohut & Wolf, 1978), perhaps for the first time.

This experience of themselves as accepted by the others in the group and developing a sense of belonging was encaptured in the name that they chose themselves for the group: #wearenotalone. The ‘we’ was deliberate and chosen instead of ‘you’ with the wish to feel a part of something. One woman remarked that she had often been told “you are not alone” but these words, in themselves, marked her as being outside, and the inclusive ‘we’ brings everyone inside. The group, therefore acted as a model of ‘common humanity’, where all of our very human qualities were brought and welcomed. The flattened hierarchy of action research and the philosophy of psychotherapeutic groups in which the research was run also meant that I shared my own human qualities of fluctuating emotions and gave an opportunity to, as best I could, model acceptance and self-compassion (see the section on ‘mindfulness’ below).

The group was therefore a micro experience of common humanity, a ‘component of self-compassion’ (Neff, 2003, p.89) which gave the phenomenological experience of being human; where anxieties and felt inadequacies were shared and accepted for what they were: human traits experienced by us all. Over the weeks, an understanding and acceptance of this softened the barriers between us within the group but also spread outside of our group as this understanding was also applied to others (see section 5.3.4 ‘Understanding Others’ in Phase 2).

### 7.5.3 Mindfulness

| **Experiential avoidance** | **Mindfulness** |
|---|---|
| Impact of trauma, Ph1,B | Understanding myself, Ph1,H |
| Experiential avoidance, Ph1,B | Recognising and accepting emotion, Ph2,H |
| | Understanding myself, Ph2,H |
| | Expressing emotions and connecting with others, Ph2,R |
| | Greater understanding of barriers, Ph3,H |
| | Understanding myself, Ph3,H |
| | Understanding the child part of me, Ph3,H |
| | From doing to being, Ph3,H |
| | Self-acceptance, Ph3 |
| | On resistance, Ph3 |

*Table 22: Themes from the research in the context of Neff's 'mindfulness' component and its trauma driven opposite; experiential avoidance.*
Key: Ph (phase); H (helpful), B (barrier), R (relationship)

Table 22 shows the deficit position of mindfulness in two themes from phase one of the research. The righthand column captures the elements, or mechanisms of mindfulness that were developing throughout the research and were particularly noted in phase three.

Neff defines mindfulness as a 'balanced state of awareness' which requires us to neither avoid difficult feelings or dissociate from them in order to accept whatever mental and emotional responses arise (Neff, 2003, p.88). In consideration of the four individual phenomenological features of shame as raised by Lewis (1992): the desire to hide; experiencing intense feelings of pain, discomfort or anger; feelings of inadequacy or unworthiness and the subjective self experienced as object, mindfulness does not directly address any of these specific areas in turn, rather supports and encourages the ability to develop an approach-focussed stance rather than practice emotional avoidance of problems. In this way individuals learn to remain, as best they can, in contact with difficulty as it is felt in the body, experienced as an emotion, or recognised as thoughts, to observe and accept them without trying to change or avoid them (Follette, Palm & Rasmussen, 2011). This approach can be particularly effective when dealing with traumatic memories as, when traumatic memories are recalled, the part of the brain involved with speech, Broca's area in the left-hand cortex, is immobilised.

Memories are therefore unavailable to be processed through language but are processed instead through the right brain hemisphere which deals with visceral experience (Rothschild, 2000). The turning towards and sitting with mindfulness approach therefore acts as a form of managed exposure (Cloitre, Koenen, Cohen & Han, 2002). Again, the interrelatedness of all three components is important, where mindfulness practices the acceptance of experience, self-kindness is the acceptance of the experiencer (Germer & Neff, 2015).

The deficit position of experiential avoidance; aversion and dissociation was clearly articulated from the very start of the research (see section 4.2.2 'Experiential Avoidance in Phase One), with the women recognising detachment was being used as a coping strategy (see also section 5.2.3 'Understanding myself').

The only formal mindfulness practiced during the research was during the daylong session and received a mixed response. However, I would argue that the mechanisms of mindfulness: intention, attention and attitude, which lead to a significant shift in perspective, or 'reperceiving' (Shapiro, Carlson, Astin & Freedman, 2006, p.377), were informally present in our sessions and this at least helped the movement from experiential avoidance towards

mindfulness. For example, using knowledge from the psycho-education session on trauma and information from the various psychological models introduced throughout the research, the women started to notice their responses to people or situations and create a different narrative around it from an observer perspective (see 'Understanding others, section 5.2.4 in phase 2). Greater objectivity was noticed; the women spoke of *having* thoughts or emotions rather than identifying as *being* an emotion. This objectively noticing one's own internal processes is suggested as a key and naturally occurring human developmental process (Shapiro et al, ibid) that perhaps was thwarted or damaged during their childhood and this open space in which to discuss and explore emotions played some part as a reparative experience. Again, this was done lightly; we did this by noticing our emotional responses to trigger, as best we could the emotion was labelled and shared. Any perception of the risk of rejection was countered by acceptance. So, rather than what could be an insular staying with in mindfulness, together we explored with curiosity what was happening in the present, learning to use our own critical subjectivity to notice our experience and see it as an interpretation, open to all the distortions that we apply to it based on our past learned experiences.

By the end of the research all the women were more able to identify their emotions objectively and less likely to practice experiential avoidance. again, this took them to a more neutral position from which to move forward, if they chose, to a more formal, structured practice of mindfulness. One of the action outcomes was to suggest running a trauma focussed mindfulness course in the agency which would be open to all service users.

### 7.6 Summary of Research Questions as applied to Neff's components of self-compassion.

Much has been written about the long shadow of CSA around self-condemnation, wanting to isolate the self and the fear of their own experienced emotions leading to experiential avoidance. All of these were articulated or manifested during this research as barriers to developing self-compassion (Research Question 1). What was helpful in moving towards self-compassion (Research Question 2) was the increasing ability of the women to understand these barriers, accept them with nonjudgement as reasonable responses following a relational trauma and treat themselves with kindness – Neff's first component. This was done within a safe space with women who had suffered the same developmental trauma, where the challenges faced in the present were shared, discussed and made sense of using psychological theories around both trauma and compassion (the role of the group: Research Question 3). Thus, critical subjectivity was extended to critical intersubjectivity of shared meaning (Heron & Reason, 1997) where the women felt understood, accepted and a sense of belonging. This micro experience of common humanity (Neff's second component

of self-compassion) extended beyond the secure attachment created within the group to beyond; that other people also experience difficulties and anxieties which in turn impacts on their behaviour creating a perception of a less harsh and hostile world. A desire to reach out and connect to other women in the agency who had not attended the group was a direct contrast to the isolation and mistrust spoken of in early sessions. Although mindfulness (Neff's third component) was only touched upon lightly in the sessions, the basic components of mindfulness - intention, attention and attitude - were present throughout and the women were able to develop the ability to notice their responses more objectively. The group therefore, I believe, acted as an foundation stage of mindfulness for possible further exploration of this if they were interested.

The importance of the group (Research Question 3) was paramount, providing the experience of other people who could be trusted and used as support. The participatory nature of action research gave them the experience of being part of something, sharing together new understanding of themselves in relation to others. They were thus restored into a circle of community which, in turn extended to the wider human community through the action outcomes (Heron & Reason, 1997). No words could sum it up better than Rhonda, who emailed Christmas wishes to the group seven months after the research ended:

> *'I want to add that the group has had a profound impact on me, especially meeting such strong and inspiring women who have managed to make me feel part of something and not alone any more'. (Rhonda, Christmas greetings December 2018).*

### 7.7 A synergy of components for therapeutic gain

It is my belief that Neff's components of self-compassion were nurtured and developed in this research group and this was achieved by the synergy of four components of the research as shown in diagram 3: a therapeutic group + action research + trauma theory + compassion theory.

I have discussed the value of action research as a methodology for empowering women who have suffered CSA and the importance of creating a holding therapeutic group. These both set the conditions within which the work was done. The sessions were then informed by research around both trauma and self-compassion and these, in turn were held lightly as possible ways in which to bring understanding, congruent with the social constructionist epistemology.

Together, these components provided a synergy for therapeutic gain, with each playing its part in bringing together experiential, presentational, propositional and practical knowing. The conditions provided the opportunity to alter the women's self-perception and relate to themselves with more compassion, thus addressing the symptom of 'beliefs about oneself as diminished, defeated or worthless', criteria two in Complex PTSD (ICD-11) (WHO, 2018, s.6B41) which is so rarely the focus of attention in other interventions. It also served to address the other interpersonal treatment goal (criteria three) of 'difficulties in sustaining relationships and in feeling close to others' by the opportunity to create multiple therapeutic alliances. Both of these treatment goals, I believe, are difficult to achieve from a therapeutic dyad alone which I have argued is inherently positioned as a 'doer done-to' positionality (Benjamin, 2004).

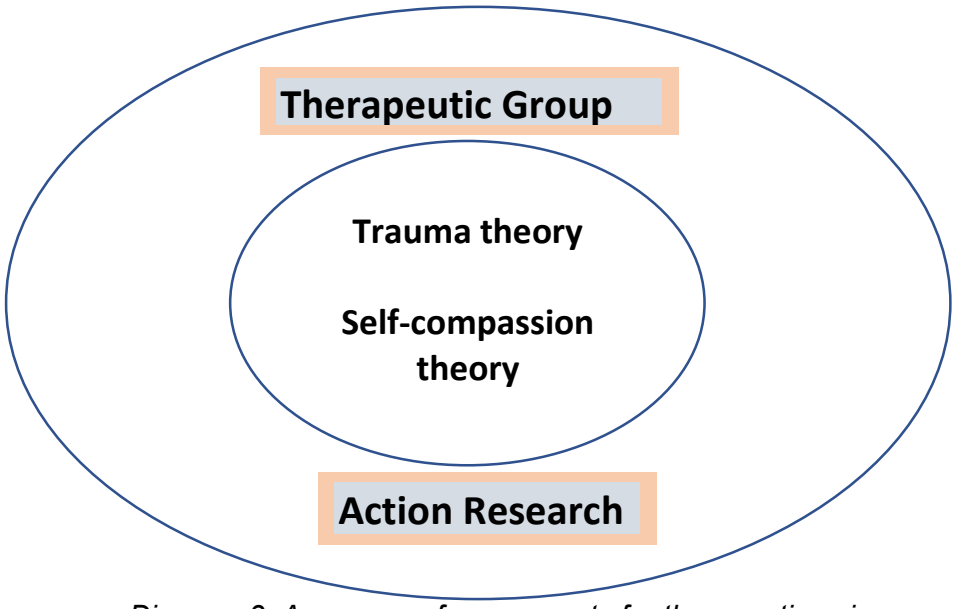


*Diagram 3: A synergy of components for therapeutic gain.*

## 7.8 Reflections on the use of action research

### 7.8.1 Challenges of an Action Research design

The challenge of genuine collaboration was always a tension in this work and already by the first session I alone had determined the scope of the research, the research questions, the format to some extent and criteria for the participants.

Other inequalities were present during the research, for example, if I was away then the session was cancelled but not for any other co-researcher. There was therefore an undeniable power difference within the room which was occasionally remarked upon:

> *Jane, you're our leader, do you want to say something?* (Laura, Week 7)

The letter of introduction I had sent out to women in the agency to invite participants positioned me with a professional identity as a therapist at the centre with academic credentials, no doubt reassuring to some but perhaps intimidating to others. There was an expectation that I would be 'in charge' perhaps stemming from their own need for someone else to be in control, possibly a parent figure and I found myself being confused myself sometimes at my role – not wanting to take control or to undermine the others but also very mindful of a need to keep focus and structure.

There were, however, advantages of this difference in power and my intention was to harness this in the service of the group; I was in a position within the agency to bring together a group and was trusted to have access to the building outside of office hours. My psychotherapy training and support of supervision meant that I was able to provide a safe space in which to explore difficult concepts in an ethical and safe way, the testament of which was that all 8 women who started, completed the research 5 months later. My power, channelled through my skills and resources, was therefore used to facilitate the opportunity for the co-researchers in the group, and they brought their power in the form of experience. Together we co-constructed new understanding of the challenges of applying self-compassion to women who have suffered CSA.

Once the sessions had started I was aware that, although I strove to create a flattened hierarchy, for the women I would always be the one who was the outsider by experience and there was some puzzlement expressed in an early session why I would be interested in researching the subject matter.

I was excluded (appropriately so) from group chats that were set up and informal meeting up outside of the group. I did not consider myself as the expert who had any answers, I was not there to fix anything or to determine outcomes, I was there to learn from them and together we decided how that would work. However, I was always the 'go to' person for general questions and additional support (although this was limited and generally redirected to their own counsellor of the Helpline to retain boundaries).

I tried to show myself as an insider in common humanity by some transparency of my own human vulnerabilities and anxieties with some modelling of appropriate coping strategies. However, there was always a boundaried difference in this; whilst they shared intimate details of their lives, I did not share personal details with the group.

Of course, as could be expected with any group of individuals, although equal opportunities were offered to take the role of Chairperson, to contribute verbally in the sessions or in writing for the newsletters, some chose not to take them. At times discussions were dominated by two or three women but all were given the space to contribute and we

frequently referred to the ‘7 Quality points of action research’ to ensure that everyone’s voice was heard.

Although there was disparity in contributions, each woman was accepted for what they contributed with no pressure to be any different from how they wanted to be in that session – some women checked in that they had had a difficult week and felt quiet and this was respected. All listened respectively and when contributions were given, these generally were to clarify or develop the thinking, showing reflective participation and engagement. Arguably, listening is also contribution; providing the space and attention for others to express themselves and feel heard. The journal question gave an opportunity for a different modality of contribution which some relished, others did not.

Whilst during the sessions it felt achievable to create a sitting alongside each other in the research, the difference in our roles and the power inherent within them was stark in the writing up and analysis stage. Here, the line felt crossed to researching *on* rather than *with* as I explored more deeply the group through a psychological lens. During the weekly sessions the women were given the opportunity to read the transcripts and my themes and comments and some checked over these and offered corrections. However, I found myself more reluctant to share the analysis part, fearful of objectifying their experiences. I overcame this by meeting the women who wanted to see the analysis (3 of 7 did) individually, which enabled me to explain further any questions and provide support as needed. I chose not to leave the written work with them for possible rumination after I had left when they were at home and unsupported. However, one woman asked me to cut and paste all comments and analysis of her contributions and send them to her, which I did.

The commitment to ongoing actions noticeably dropped once the weekly meetings stopped and I feel that this would have possibly been different had I the time to support this more. Despite the intention of the flattened hierarchy of the group the power differential of myself (therapist and Trustee of the agency) and the service users was inescapable and I believe that the SUN group could be viable but would need ongoing support and encouragement. There were some situational factors at play here, for example, two of the women had time-consuming new jobs. However, I also believe that this perhaps speaks of the continuing challenges the women face in confidence and self-belief as recognised in the ICD-11 criteria for Complex PTSD (WHO, 2018, s.6B41) and the long shadow of childhood abuse.

The methodology of action research also caused some unexpected difficulties. One woman wrote in her final feedback that she had not got what she wanted out of the group because she had wanted researcher experience (she did then say that she had got ‘much more than

this'). Despite transparency about the methodology in the information sessions and the Participant Information Sheet, a rigidly held idea of what 'research' is seemed to lead to a disconnect here with what was experienced.

For another woman, this disconnect meant that, a year after the research group had finished meeting, she questioned whether she had given consent for a group which turned out to be therapeutic, arguing that she had not sought therapy. Ethics were checked again by myself, my supervisor and the Ethical Scrutiniser at Metanoia with the conclusion that informed consent had been given for the research that occurred. However, it highlights that consent can only be given to be involved in the process, not the content or outcome of an action research project. Re-reading the information sheet (Appendix 6), I wonder how this could have been made clearer and I would consider seeking guidance from the original co-researchers if I were to run a similar group in the future to ensure that I am not making assumptions when I am outside the lived experience of another.

I was left with a sense of sadness and disappointment that the co-researcher perceived that she had been misled. It shows the challenges of working with a client group who have been damaged in relationship and who, understandably, can hold rigid boundaries over the permissions they give. Had this been raised during the group then, as a group it could have been discussed. However, it was raised a full year after the group sessions ended, and, at the time she had given positive feedback. It felt that something else was being enacted here, and we were not in an ongoing therapeutic contract to explore it. I felt helpless and some sense of professional discomfort as she took this to her own therapist in the agency.

It was also an anxious and stressful time for me as the feedback from the woman was escalated from my Research Supervisor to the Research Lead at Metanoia and then the Metanoia Ethical Scrutiniser. Despite their support I was aware that I was experiencing a level of shame that somehow I did not 'do' something wrong but that I, somehow, was wrong. My own critical voice around daring to think that I could lead such a group was triggered and it was a test of my own self-compassion to keep this regulated. I reflected on how vulnerable and upset I felt around this short term challenge which was small compared to the enormity of the co-researchers shame and feelings of worthlessness. Fortunately, for me, very quickly a positive response was received from Metanoia and Middlesex University confirming that I had taken all ethical measures to ensure safety of the co-researchers. However, the niggling concern that the agency thought less of me continued and the worry that the probably Person-Centred Trainee Counsellor and her Supervisor might question my

integrity when I had no way of correcting this. I also didn't want anything to damage any confidence in future possible activities of myself or the co-researchers at the agency .

### 7.8.2 Relational complexities

The relational damage done in the past continued to play out in the present. While the women learned to trust each other as peers with commonality of experience, their relationship with me was more complex. This became more apparent after the group sessions had ended and I was immersed in writing up.

One woman struggled with accepting that the ending of the research meant an ending of a relationship with me. I was, in turn, held on a pedestal and demonised for abandoning her. She had spoken in the group about her difficulties in understanding boundaries and recognised this as a repetitive pattern of behaviour. Without the face to face contact of the group I was unaware of what I was inadvertently triggering in her until I started to receive angry and terse messages from her. This raised again the complex area of boundaries when a clinician is in the role of a researcher. The research had stretched to over 5 months and with the addition of the conference, to 11 months. The research was designed to use relational practice to explore self-compassion after a relational trauma and over the months a deep respect and rapport had developed. The co-researchers were not my clients and, following the ethos of action research, not even participants. I was always friendly, to all of the women, but they were not my friends. We were co-researchers and yet I had a duty of care to monitor their welfare which was not reciprocated.

I managed this by being professional and respectful but holding boundaries and not slipping into a different role or a friendship relationship that the participant was seeking. If this had been a therapy group, and I was in the role of a Psychotherapist, this could have a been a reparative opportunity to learn a new way to relate to another woman. However, I was very conscious that she was not my client, nor I her therapist, and in my role as a researcher it was not appropriate for me to be the person supporting her through it. She sought counselling support from the Agency but it was a source of discomfort to me to know that I was the cause of difficult feelings which was the opposite of the intent of the research. I also felt a personal sense of guilt that the relationship had been taken as friendship by someone who found it difficult to make friends and who now felt rebuffed.

By the end of the group meetings, followed by immersion in the analysis and writing up, whilst simultaneously working in Private Practice and also with EUPD clients with suicidal

ideation in the NHS, I found myself utterly depleted and low in mood. I recognised that I was caught in a dilemma of not wanting to feel as though I had used the women for research and was now abandoning them, whilst also acutely aware that I did not have the time and the emotional capacity to be an ongoing source of support for them. Some post research reading around this area highlighted to me that difficulties ending involvement with vulnerable people after developing a personal rapport is not an uncommon experience (for examples see Liamputtong, 2007; Dickson-Swift, James, Kippen & Liamputtong, 2007). The flattened hierarchy of action research, I think exacerbated this where we had worked together on this challenging topic. They had learned to trust each other and formed some friendships within the group. I had presented myself as equally working with them but was not willing / able / interested in continuing those relationships informally, although I would support and work with a SUN group. I felt terribly guilty.

This could possibly be helped in future groups by sharing the practical and emotional load of working with vulnerable people post trauma with other professionals. For example, two or three people working with the group and with an ongoing commitment for the group, or a variation of it. This would help to attend to the needs of the group and each other.

Although I had given much attention to care of the participants during the research and had 'ticked the box' around self-care, the personal impact of doing this type of work, where I was sitting alongside self-judgement and a sense of hopelessness, was difficult to envisage beforehand. Despite good supervision, a sense of isolation and sadness prevailed especially during the writing up period as my own and the women's experiences were revisited again and again in the privacy of my own home. This was compounded by the feelings of guilt around the co-researcher who felt that I had rebuffed her and then, a year later in the final stages of writing up, the co-researcher's concern that she had inadvertently received therapy. It is a responsibility working with vulnerable people and I had to remind myself of the very real benefits that had been felt and the long shadow of sexual abuse. It was naive to think that this one piece of work could resolve and restore relational safety as the women navigate through their complicated lives but hopefully they will be able to use their own personal therapy to greater explore their relational challenges. To ensure my own self-care after handing in my written work I took 3 months off work away from people talking to me about their hopelessness to walk in the mountains and regain my sense of equanimity.

### 7.8.3 Limitations of the research

The design of the research meant that each week I transcribed the session and decided on main themes, providing a copy for the group in the room in the following session. More time between sessions would have given me greater time to reflect on the session, however, this would have been advantageous to me at the expense, I think, of the cohesiveness of the group.

This group of individuals were particularly engaged, showed impressive reflective awareness and the motivation to create action points. Each group is unique and I would be interested to replicate the same process with another group (leaving the content to be agreed collectively to engender the same feelings of agency). The research element, I think, gave the group a collective responsibility to take the group seriously and provide some outcomes and I wonder if it did not have this element whether there would have been the same commitment to the project. This gave their task some gravitas and themselves a role as individuals whose opinion was sought after and valued, especially important where this had been ignored in the past. Therefore, it may be important to define future groups as conducting research more perhaps for improving services to that client group rather than as an academic endeavour.

Viewing the group through the framework of social psychology also could throw light on the function of the group for the individual. What was not explored with the women, but would have been interesting, was their perceptions of the group identity. The original information sheet and flier was not telling them about a support group (with the implicit message that they are victims in need of support), but a research group asking for co-researchers. This positioning, perhaps, created an identity of themselves as capable women whose skills / opinions were sought. The endorsement by the agency of the group also helped to create a collective identity as something which was seen to be important. The successes shared within the group (see section 5.5) gave the group itself a positive identity and an attachment to something which was felt to be good and of value. Some of the women were also members of a support group in the agency and it would have been interesting to explore their perception of each group's identity and their individual identities within them.

The insight this small group of women made into their own ways of being in the world may throw some light on what may be helpful to other women who have been sexually abused as children. Congruent with the epistemology of social constructionism, this research did not reveal any concrete 'truths' which could be generalisable to the wider population and I suspect that a different selection of models / theories by a different therapist with different interests of what might be helpful to explore (for example, CBT models or drama therapy) would have equally interesting and experienced as enlightening /helpful. I believe the

process rather than the content was the catalytic agent in this research for healing. Of value would be repeating the approach of a therapeutic group using action research which provides the conditions within which people are empowered to find their own truths and this could be done with many different client groups.

## CHAPTER 8: CONCLUSION

The damaging sequelae from complex trauma is widely recognised and captured in the literature. This research followed a group of women who had experienced CSA as they explored together the challenges of developing self-compassion. Although the damage from alterations in self-perception leading to beliefs of oneself being diminished and the difficulties in relationships are now recognised within ICD-11, there is little focus on this relational aspect in current trauma interventions.

It is my contention that the format of this action research group, in which theories of trauma and self-compassion were explored, provided a synergy of components for therapeutic gain. The group provided the safety, courage and space to show vulnerability which is the antithesis of shame. That vulnerability was met with understanding, acceptance and compassion by another who could recognise that emotion in themselves, understand it at a felt level and still hold that person in positive regard. This gave an opportunity for repair and a new way of seeing oneself in the eyes of another. The vital component to this was that this 'other' was not a professional who was outside of the experience but reflections of themselves who had no agenda of wanting to fix or change, only sit alongside and bear witness. This experience of empathic reciprocity gave the participants permission to honour their own experience rather than disavow it and to connect with the internal nurturing mother who did not or could not protect the child in the past.

This was my first action research project and it has transformed my thinking around the power of groupwork and the importance of agency that is inherent in the process of this approach. When I introduced the speakers from the group at the agency National Conference, I spoke briefly about the intention of the research to understand the problem of self-compassion in women who had survived childhood abuse. I remarked that I was sure they had also worked with women who struggled with self-compassion and 200 fellow delegates representing all branches of the agency across the country nodded at the familiar problem. Then the women co-researchers brilliantly articulated their experience of moving from feelings of worthlessness and isolation to feelings that they mattered and belonged after engaging in an action research project where they themselves explored this difficult topic. It seemed that the answer had always been there within our reach, we had simply forgotten to ask the people who had the experience.

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# APPENDICES

## APPENDIX 1: RECRUITMENT EMAIL AND FLIER

Email sent to all agency service users 3/11/2017.

**Do you struggle with self-compassion?**

Research has shown that women who have experienced sexual abuse as children find self-compassion particularly difficult, often showing huge kindness to others but none towards themselves.

I have been a counsellor at xxxx for over four years and want to get together a group of women (6-8) to explore different approaches together.

Let's see if we can find out:

v **Why is it so hard to be kind to ourselves?**
v **What might be helpful?**
v **What is not helpful or gets in the way?**

I don't have the answers, I am looking for women to research this with me. Meeting weekly at our new premises in xxxx, starting in January 2018, together we decide what we look at and how we go about it.

This project forms part of a qualification I am taking so will be written up and submitted to a university. **All information that is collected about you during the project will be kept strictly confidential. Any information about you which is used will have your name and personal details removed so that you cannot be recognised from it.**

If you are interested please come along to one of the information sessions I will be running at the end of the month:

**Information Sessions:**
**27th November 2pm - 3pm or 6:30pm - 7:30pm.**
**Venue: xx Centre in xxxx**

**Please let me know that you will be coming on jane.barker@metanoia.ac.uk or if you have any questions.**

You don't have to have any experience of doing this type of thing before. My thoughts are that we would meet for a weekly session starting in the new year and each week look at a different way of

looking at the subject. But I haven't planned a lot - the idea is that we, together, decide how we will approach this.

# Do you struggle with self-compassion?

Research has shown that women who have experienced sexual abuse as children find this area particularly difficult, often showing kindness to others but none towards themselves.

I have been a counsellor at xxxx for over four years and want to get together a group of women (6-8) to explore different approaches together. Let's see if we can find out:

- **Why is it so hard to be kind to ourselves?**
- **What might be helpful?**
- **What is not helpful or gets in the way?**

I don't have the answers, I am looking for women to research this with me. Meeting weekly at the new premises, xxxx, starting in January 2018, together we decide what we look at and how we go about it.

**All information that is collected about you during the research will be kept strictly confidential. Any information about you which is used will have your name and personal details removed so that you cannot be recognised from it.**

## Interested?

**Find out more at an Information session: 27th November 2pm – 3pm 6:30pm – 7:30pm**

**at xxx, xxxx.**

**Please let me know you will be coming or if you have any questions:**

Contact: **Jane Barker** jane.barker@metanoia.ac.uk

**APPENDIX 2: SEVEN QUALITY CHOICE POINTS OF ACTION RESEARCH (BRADBURY, 2014)**

| |
|---|
| 1. Articulation of objectives: The extent to which the objectives and the choices are clear. |
| 2. Partnership and participation: The extent to and means by which participative values and concern for the relational component of work is maintained. By the extent of participation, we are referring to a continuum from consultation with stakeholders to stakeholders as full co-researchers. |
| 3. Contribution to theory/practice: The extent to which the work builds on (creates explicit links with) or contributes to a wider body of practice knowledge and or theory. |
| 4. Methods and process: The extent to which the action research process and related methods are clearly articulated and/or illustrated. It is important to "show" and not just "tell" about processes. |
| 5. Actionability: The extent to which the work provides useful ideas that guide action in response to need. |
| 6. Reflexivity: The extent to which self location as a change agent is acknowledged. By self location we mean that participants take a personal, involved, and self-critical stance as reflected in clarity about their role, clarity about the context in which learning takes place, and clarity about what led to their involvement in this research. |
| 7. Sustainability: The extent to which the insights developed are significant in content and process. By significant we mean having meaning and relevance beyond their immediate context in support of the flourishing of persons and wider communities. Clarifying the infrastructure that can support ongoing maintenance of the work is key. |

**Seven Quality Choice Points of Action Research Bradbury (2014), paraphrased for the group.**

Remembering:

1. Why are we here? (our goal)
2. Are we all involved? (everyone's voice is important)
3. Does this make sense? (link to other theories)
4. Nothing's hidden
5. Is it helpful? To ourselves? Potentially to others?
6. Are we allowing ourselves to learn as much as we can?
7. How can we make this last?

**APPENDIX 3: THEMES AROUND THE RESEARCH QUESTIONS – WEEK 5 – THE MODEL AND REVIEW**

| WHAT IS HELPFUL IN MITIGATING FEELINGS OF LOW SELF-WORTH, ISOLATION AND SELF-CRITICISM? | WHAT ARE THE BARRIERS TO DEVELOPING S.C AND CAN THEY BE OVERCOME? | WHAT IMPACT IS THE ROLE OF RELATIONSHIP IN THE GROUP IN DEVELOPING S.C? |
|---|---|---|
| <u>Taking control</u> discussion around this leading to empowerment.<br><br>"My dignity belongs to me" Taking control of job situation and relationship. Telling the police on Valentine's Day.<br><br><u>The model</u><br>"I keep thinking the research is about self-respect"<br><br>Agreement around 'healthy control'<br>Making our own choices. "Anger is self-respect".<br><br><u>Normalising – impact of trauma</u><br><br>"tears – let them flow. I recognised that there was nothing wrong with me". | <u>Self-judgement</u><br>"thinking that I've annoyed everyone". "Soppy tits".<br><br><u>Pleasing others (and their boundaries)</u><br>So that they give us the compassion we are looking for. "it's on empty, or low, so I try to get it from somebody else".<br><br><u>Fear of rejection</u><br>"so I give my power away"<br><br>Pushing others away – creating isolation. "Telling others about me so they will retreat".<br><br>Fear of upsetting others by 'telling'.<br>Re-enactment from the past – don't tell anyone because they'll be hurt. "Am I wired to keep my mouth shut or am I making a choice?" | <u>Connecting / reassurance</u><br><br>Appreciations and hopes in check-ins – appreciations for honesty.<br><br>Respect for sharing.<br><br>A co-researcher being able to articulate that she feels her voice his not important enough to be heard. Prompting reassurance from the others that her voice is valued. |

| | | |
|---|---|---|
| | <u>Feelings of worthlessness</u><br>“I don’t matter enough for people to be hurt”. | |

**APPENDIX 4: SUMMARY OF THEMES APPLIED TO NEFF'S THREE COMPONENTS OF SELF-COMPASSION.**

| **Hope and belief in personal agency** | |
|---|---|
| **Self-condemnation**<br>The Impact of trauma Ph1, B<br>Shame Ph1, B<br>Sense of self and self-judgement Ph1, B<br>Secondary suffering, Ph1, B<br>Shame, Ph2, B | **Self-kindness**<br>Doing something for me Ph1,H<br>Noticing moments of self-compassion, Ph2, R<br>Understanding & accepting the child part of me, Ph3, H<br>Reflected in the eyes of another, Ph3,R<br>Self-acceptance, Ph3<br>Examples of greater self-compassion, Ph3 |
| **Isolation, fear and mistrust of others**<br>Daring to connect, Ph1, R<br>Impact of trauma, Ph1,B<br>Shame, Ph1,B<br>Impact of developmental trauma, Ph2,B<br>Trauma schemas, P2,B<br>Holding boundaries, Ph2,B<br>Needing acceptance and wanting to please, Ph2,B | **Common Humanity**<br>Finding commonality & a sense of hope, Ph1,R<br>Seeking kinship / acceptance, Ph1, R<br>Daring to connect, Ph1,R<br>Understanding others, Ph2,H<br>Acceptance and belonging, Ph2,R<br>Expressing emotions and connecting with others, Ph2,R<br>Learning from and with each other, Ph2,R<br>Feeling accepted, Ph3,R<br>Healing relational trauma in relationship, Ph3,R<br>Reflected in the eyes of another, Ph3,R |
| **Experiential avoidance**<br>Impact of trauma, Ph1,B<br>Experiential avoidance, Ph1,B | **Mindfulness**<br>Understanding myself, Ph1,H<br>Recognising and accepting emotion, Ph2,H<br>Understanding myself, Ph2,H<br>Expressing emotions and connecting with others, Ph2,R<br>Greater understanding of barriers, Ph3,H |

| | |
|---|---|
| | Understanding myself, Ph3,H<br>Understanding the child part of me, Ph3,H<br>From doing to being, Ph3,H<br>Self-acceptance, Ph3<br>On resistance, Ph3 |
| **Altruism**<br>Ph1,R; Ph3,H, Ph3. | |

**Table 20, Summary of themes applied to Neff's three components of self-compassion**

Key: Ph (phase); H (helpful), B (barrier), R (relationship)

## APPENDIX 5: PARTICIPANT INFORMATION SHEET

**METANOIA INSTITUTE**

**AND MIDDLESEX UNIVERSITY**

**PARTICIPANT INFORMATION SHEET**

**Exploring Compassion: An Action Research study with women who have been sexually abused as children as 'expert by experience' co-researchers.**

**Invitation**

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

**What is the purpose of the study?**

Research has already shown that a lack of self-kindness / compassion is a common response to sexual abuse in childhood. As a counsellor myself with xxxx for over four years, I have been struck by how many women I have worked with 'beat themselves up', often showing enormous kindness to others but none towards themselves. Often this high level of self-criticism leads to feelings of low mood or isolation from others.

I am interested in getting together a group of women so that together we can look at different approaches designed to help people develop more compassion / kindness towards themselves. You are the experts – I want to join with you to explore different approaches. I can show some different ideas about developing self-compassion but you get to choose what to you'd like to find more out about and together we'll see what is helpful or unhelpful.

**Why have I been chosen?**

You have been approached to take part in this study because you are a service user of xxxxx. I am looking for 6 – 8 survivors of childhood sexual abuse who find self-kindness / self-compassion difficult, to be co-researchers with me on this topic.

**Do I have to take part?**

It is up to you to decide whether to take part. Taking part, or not taking part in this research will not affect your ability to access any of the other services the agency offers. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form which you will also keep a copy of. If you join the group you are still free to withdraw at any time without giving a reason and again this would not affect your ability to access any other of the services xxxx offer.

**What will happen to me if I take part?**

There will be **information sessions 27th November 2017** where you can meet me and other women who might be interested, hear more information about the research and have the opportunity to ask any questions you may have.

If you decide you would like to join in and be a co-researcher, I will first meet you individually to have a chat about what self-kindness means to you personally. This will be an additional opportunity to ask any questions and for us to start to get to know each other.

It is known that women who have experienced sexual abuse as children find this area particularly difficult so I would like to take this opportunity to see how working together in a group might be helpful. In the group, we will look together at the whole area of self-kindness, why it can be so difficult and what gets in the way of it. This is **our** study and you will be involved very step of the way – from deciding what we do in the sessions, to looking at common themes and, if you want to, interpretation of our findings. Perhaps after the research is completed it could even be used to help other women with similar experiences.

**It will never be a requirement for you to give any private or personal details about your history, unless you choose to. You will never be put on the spot and can opt out**

**of any activity you choose to. The intention is to form a caring group of like-minded women to help each other. We will agree together how the group wants to work together to create trust and support.**

It is hoped that we will be able to meet weekly at the xxxx offices (day of the week and time to be confirmed based on what everyone can do), starting in January 2018. In the initial sessions we will get to know each other and learn a bit more about how trauma affects the body and why self-kindness can be a hard thing to do. Then we can start to look at different approaches and decide together what we would like to explore further.

This is *your* group though. I am there to help facilitate and keep us on track for the aims of the study but you all decide how that will happen. After 12 weeks of working together we will review where we are and decide what we want to do next. At some point it is possible that I will leave the group but the group could decide to still meet up and continue the work.

**What do I have to do?**

After the initial sessions, it is hoped that the group will spend each week exploring different ideas around self-kindness. For example, this could be around mindfulness one week and artwork or writing another week. A group member may have something she wants to find out about and lead, and that's great. But no-one will be expected to do anything they don't want to. The sessions will be audio-recorded so that I can keep track of where we are in the research.

Every 4 or 5 sessions we will do a review of where we are against the themes we identified at the beginning. We can choose how we want to do this: discussion, using art, poetry, writing or even drama – it's up to the group. I will record the review sessions, type it up and group members can get a copy to check and comment on.

**What are the possible disadvantages and risks of taking part?**

Exploring a lack of self-compassion and reasons why we might 'beat ourselves up' may bring up difficult feelings. I will make every effort to make everyone feel supported and we will be there to help each other. The xxxx 'help line' is also always available for extra support.

**What are the possible benefits of taking part?**

I really hope that participating in the study will prove helpful. However, this is a difficult area and cannot be guaranteed. Whatever we find out may be helpful to other women who also find self-compassion difficult.

**Will my taking part in this study be kept confidential?**

All information that is collected about you during the research will be kept strictly confidential. Any information about you which is used will have your name and personal details removed so that you cannot be recognised from it.

All data will be stored, analysed and reported in compliance with the Data Protection legislation in the UK. This means that all recorded and written material is kept secure while the study is ongoing, and will be destroyed after completion.

The audio recordings from the interviews and review sessions will be moved to a password protected computer document and then immediately deleted off the recording device. Transcripts from the interviews and review sessions will be stored in password protected files and will not include any identifiable information to maintain confidentiality. The identifiable information will be kept separate and you will be anonymised using a code system.
Identifiable information such as geographical locations and names will be changed. Your anonymity will be maintained in any written or verbal dissemination of the research.

**What will happen to the results of the research study?**
This study is part of a qualification I am taking to be a Counselling Psychologist. That means that any individual interviews and sessions will be recorded and I will be writing up what we have found.

**Who has reviewed the study?**

This study has been reviewed and approved by:
Metanoia Research Ethics Committee
Metanoia Institute

13 North Common Road
Ealing
London
W5 2QB

**Contact for further information**

If you have any questions or concerns at any point, please feel free to contact me or the Metanoia Institute. Contact information is below.

**Jane Barker (researcher)**
13 North Common Rd
London W5 7HJ
Email: jane.barker@metanoia.ac.uk

**Dr Patricia Moran (research supervisor)**
c/o Metanoia Institute tel. 020 8579 2505

Thank you for taking the time to consider being part of this study.

**APPENDIX 6: CONSENT FORM**

**CONSENT FORM**

Participant Identification Number:

**Title of Project: Exploring Self-Compassion: An Action Research Study with Women who have been Sexually Abused as Children as 'Expert by Experience' Co-Researchers**

Name of Researcher: Jane Barker

1. I confirm that I have read and understand the information sheet dated ..... about the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided. ☐

3. I understand that the sessions will be taped and subsequently transcribed ☐

4. I agree to take part in the above study. ☐

5. I agree that this form that bears my name and signature may be seen by a designated auditor. ☐

_____

Participant's signature Date

_____

Researcher's signature Date

1 copy for participant; 1 copy for researcher

## APPENDIX 7: SELF-COMPASSION GROUP – HOW WE ARE GOING TO WORK TOGETHER

**(notes from session 1 fed back to the co-researchers).**

### Capturing our sessions

Brought attention to the group that the session was being recorded and everyone had signed a consent form.

Discussed how to honestly be able to capture the thoughts, feelings and experiences of everyone in the group. Transcribing the whole 2 hour sessions is one way – offer of help from one C.R. which was acknowledged but politely declined – too much pressure on one member of the group. Suggestion to use someone ( a woman) outside of the group but only if everyone was in agreement. CR would always be able to ask for any parts not to be heard by this person, in which case Jane would transcribe it. Requested by a CR that the person signs a Confidentiality Agreement which was agreed. Group asked to think about it so no rush decision is made. Voice recognition software also suggested and using two recorders to ensure that taping is happening.

Group did not wish to have transcript sent to them to read (data protection concerns and the pressure to read large amounts of script), instead it was agreed that one copy is left to be accessible on the day.

Jane confirmed that she would be transcribing and then picking out themes with giving transparency of where the themes had originated. This would also be circulated and everyone has the opportunity to clarify or change. The group decided to see how this goes with a view to review and change if necessary.

Some CRs also ‘think’ in pictures – some paper and pencils in the room would help to capture this.

### How much information are we going to share about our past?

The group agreed:

- That it is inevitable ‘the past’ will come up but that it is not the focus of our sessions
- Everyone in the room knows that there is that shared experience but even though an individual is okay to talk about it, others might not want to hear, and that’s okay.
- No-one is ever expected to talk about their past

- It should also not be the ‘unspoken’ thing in the room
- An intention of shared compassion in the room is there – people may have a tear but that is okay and shows that we care about the other person so they shouldn’t worry about upsetting someone else
- Some people find it hard to cry in front of others and react to difficult emotions in a different way – such as laughing
- We won’t be surprised if we worry about upsetting other people rather than our own upset because that shows our lack of self-compassion which is why we’re here!
- If someone feels that they need to leave the room that’s okay – after 5 mins either come back or someone will come and see if you are ok
- Buddy system? Each person is a ‘watch bird’ for someone else?

**Confidentiality**

The group agreed:

- Individual group members may want to talk to their own professional support e.g. counsellor but this should never include personal information e.g. the other person’s name or where they live
- “I want to control my own story” after other people have taken that control away

**Bumping in to each other outside the group**

It was agreed that if seen outside the group everyone would like to be acknowledged without being it being referenced where they are known from. It was also mentioned that if someone is not acknowledged it could be because they weren’t recognised rather than deliberately ignored!

**7 Quality Points of AR**

Will be displayed in the room and reviewed to ensure that we are following them:

1. Are we clear of our goal?
2. Are we all involved? Everyone’s voice is important
3. Does this make sense?
4. Nothing is hidden – transparency throughout
5. Action: is this helpful to me? To others?

6. Are we getting everything we need from this? If not, why not? Can we do anything about that?
7. How can we make this last?

Thoughts on the above:

- Having someone to facilitate – to keep an eye on the time and make sure everyone is heard (don't call them the 'chair')
- The facilitator role can be taken by different people, but no-one is expected to do it if they don't want to
- Group members have asked that they are not 'put on the spot' to contribute
- The opportunity to 'check in' and 'check out' gives the opportunity for everyone to be heard
- The facilitator can make sure that we are kept on topic – unless it is a relevant side line
- As a group we should look out for the topic we avoid

**Journals**

- Can be used to capture thoughts after the session.
- Are confidential – no-one will ever be asked to show them but can choose to read out from them or offer content from them to the group
- They will not be collected at the end of the project
- A CR suggested that a question is set each week for reflection and review the following week
- A couple of CRs asked if they could make notes during the session – no disagreement to this

**Agenda**

Useful to have a time frame but not rigid.

10am Check in

Summary of last week - journals

Start topic for this week

10:45 to 11:15 Break (perhaps aim for 11:00 but see how it works)

Topic for the week continued. At the end, do we want to take this topic forward or leave it behind? Reflection question for this week?

If leaving behind, plan for next week.

11:30 Check out

11:50 Feedback forms

12:00 Close

**Feedback forms**: 3 different looked at:

HAT (Helpful Actions of Therapy). Comments – would need to take this away and think through it to bring back. General option that "it sounds a bit involved".

2nd form – linked to aims of research: "sounds more helpful"

3rd form – no prompts.

Group decided they preferred the 2nd one. Decision made to use real first names if happy to do that but for no other details to be carried by Jane so that if lost, no-one could be identifiable.

**Absences from group** – it was raised that if someone didn't come to a session others may worry, it was agreed that people would send apologies if unable to make a meeting.

**Re. two people who did not come this week** – suggestion that they are 'caught up' with what we covered. Mixed feelings about them attending – it might be difficult for them to now join the group now that a dynamic has begun but also everyone didn't want to say "no". It was aired that it would be quite difficult for them to come in to the group where everyone else has met already.

It was agreed that no-one else would be able to join the group now but that these two people have already been to the Intro Sessions. It was agreed that all of us might not be able to make one week for a reason or another – childcare / illness / holiday and that's okay but apologies should be made rather than not turning up.

**Group name – not covered – to think about for next week. Suggestion: 'The Compassionates'.**

**Journal question: Given the problem / question at the heart of the group (i.e. that we all struggle with a lack of S.C), where does this show up in the group / in our work together.** Email will be sent to confirm this again. Suggestion is for everyone to think about this and write in diary if they choose – this is not homework! Equally okay to notice that the question is something we don't want to explore and think about that.

**Parking –** if we all park close to each other then we should all fit in. Everyone reminded to park within the allocated slots.

Future dates: Group were warned that I (Jane) am away 1st week February.

## APPENDIX 8: PHASE 1: FOCUS OF WEEKLY SESSIONS AND PSYCHOLOGICAL MODELS / APPROACHES INTRODUCED.

| WEEK | FOCUS OF SESSION | MODEL / THEORY | TYPE OF COMMUNICATION |
|---|---|---|---|
| 1 | Introductions and how we will work together<br>Journal question: 'How will a lack of self-compassion show up in the group?' | | |
| 2 | Planning.<br>Journal question:<br>'What coping mechanisms have I used and find useful – or used and find not helpful?' | | |
| 3 | Coping<br><br>Journal question: How have I noticed I have been affected by trauma?<br>Invitation to write this as 'sometimes I notice…' | 'Hot cross bun' CBT model: how our thoughts, emotions, behaviour and physiological response are all interlinked.<br><br>How we:<br>Have an emotional reaction to a trigger (e.g. feeling upset)<br>Have a secondary emotional reaction to having the emotional reaction (secondary suffering e.g. I'm so stupid for feeling upset).<br>Have a behavioural response to the above (e.g. eat lots of chocolate and feel bad about that).<br><br>Practicing 'the observing self': sometimes I notice that I get feelings of upset".<br>The concept of *having* an emotion not *being* an emotion. | Explanation by me.<br><br>'Cushion' exercise showing secondary suffering. |
| 4 | Psycho-education on the impact of trauma.<br>Journal question / reflection: if there is anything that has stood out from today's session that might help me understand what's going on and help you going forward'. | How trauma affects the brain: hippocampus, Broca's area, amygdala (informed by Judith Herman). 'Window of tolerance' explained. | Explanation by me.<br><br>A selection of trauma books brought and left in adjoining room to be looked at in the break if they wished. |

| | | | |
|---|---|---|---|
| 5 | Our framework and review<br><br>Journal questions:<br>1.Boundaries – 'what makes it so hard to make / keep them and any ideas for overcoming this?'<br>2. 'What have we learned already that might be helpful - for us? For others? Who?' | <u>Coping techniques:</u><br>Grounding<br>Square breathing<br>Short mindfulness practice (noticing the breath)<br><br>Babette Rothschild 8 keys to safe trauma therapy.<br><br>Amy Cuddy – Fake it 'til you make it' re. body language. | Demonstration by me.<br><br>Link emailed of You Tube video after session.<br><br>Link emailed of You Tube video after session. |

## APPENDIX 9: PHASE 2: FOCUS OF WEEKLY SESSIONS AND PSYCHOLOGICAL MODELS / APPROACHES INTRODUCED.

| WEEK | FOCUS OF SESSION | MODEL / THEORY | TYPE OF COMMUNICATION |
|---|---|---|---|
| 6 | Boundaries<br><br>Journal question: 'what are our boundaries?' | Article sent from Psychology Today on boundaries.<br><br>Link to TED talk: 'Saying no to say yes' by Dr Caryn Aviv. Transcript also sent.<br>Coping strategy (meditation) sent to me be a group member and forwarded to others.<br><br>I'm okay, you're okay (Harris, 2012) | Link to website sent by me.<br><br>Discussed in group and sent out as link to TED talk by me. |
| 7 | Boundaries 2 and review.<br><br>Journal question:<br>'what is the role of relationship in the group in developing self-compassion?' | | |
| 8 | Doing this together – the impact of being in a group<br><br>Journal questions: how do we trust ourselves, and others, in order to feel more connected with them? How does this help | Difference between self-compassion and self-esteem. The 3 components of self-compassion. Overcoming objections to self-compassion (K. Neff)<br><br>Autobiography in Five Chapters. Poem by Portia Nelson.<br><br>Attachment theory, Bowlby.<br><br>Fed up Honeys<br><br>The Power of Vulnerability – Brene Brown | Explanation by me. A group member sent me a link to a You Tube presentation by her for me to forward on.<br><br>Read out in the session.<br><br>Explained in session.<br><br>E.g. of another action research group's newsletter.<br><br>Link to You Tube video of her presenting. |

| | | | |
|---|---|---|---|
| | us to be more connected to ourselves? | | |
| 9 | Trust.<br><br>Journal question / reflection: Do I recognise when I am in 'threat' mode and, If so, can I use my 'wise mind' to reduce that feeling of threat and self soothe (i.e. bring compassion to that part of me?. | Paul Gilbert: Compassion Focussed Therapy model.<br><br>Negativity Bias<br><br>Janina Fisher neurobiological response to trauma and the 'fragmented parts' of us | Discussed in group and worksheet sent on Compassion Focussed Therapy from Psychology Tool.<br><br>Discussed in group and link to a Rick Hanson article sent.<br><br>Discussed in group and You Tube videos recommended for further reading. |
| 10 | Assertiveness | | |

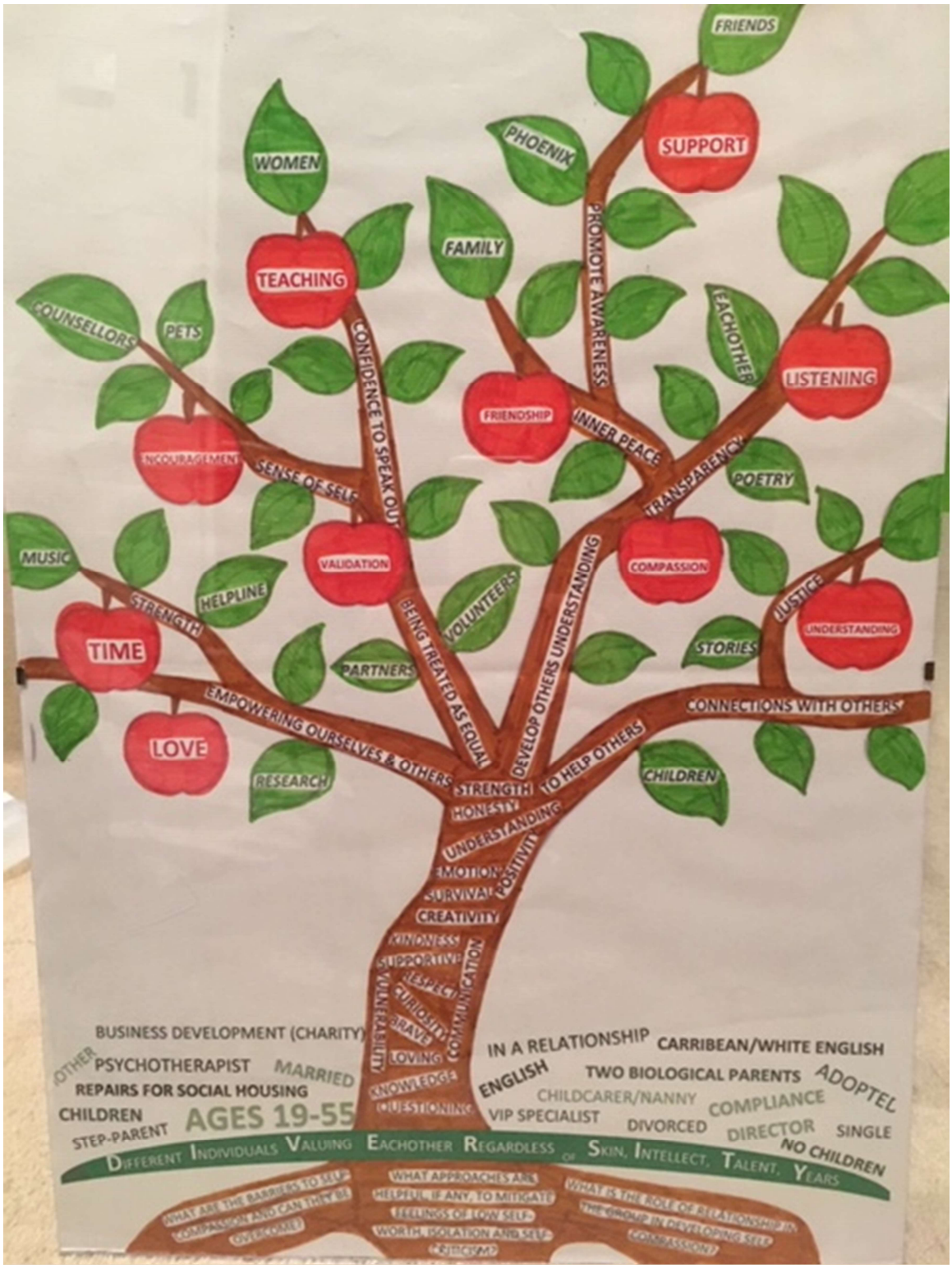
**APPENDIX 10: PHASE 3: FOCUS OF WEEKLY SESSIONS AND PSYCHOLOGICAL MODELS / APPROACHES INTRODUCED.**

| WEEK | FOCUS OF SESSION | MODEL / THEORY | TYPE OF COMMUNICATION |
|---|---|---|---|
| 11 | All day session. | Mindfulness practices: Sitting with the breath, finding a 'self-soothing gesture'.<br>Visualisation: 'Safe Space'.<br>Building a compassionate Image (Paul Gilbert).<br>Noticing Difficulty Practice (Mindful self-compassion)<br>The Loving Kindness Practice.<br><br>Poetry.<br><br>Group 'Tree of Life' | All mindfulness practices run by myself (a registered mindfulness teacher with 6 years' experience of running MBSR) with additional guidance taken from Magyari (2015).<br><br>Selected from my mindfulness courses.<br><br>A recovery focussed exercise used in mental health with origins in Zimbabwe to help traumatised communities find a way to speak about their lives. |
| 12 | Review of the research questions | | |
| 13 | Endings and next steps | 'Appreciation' hand | |

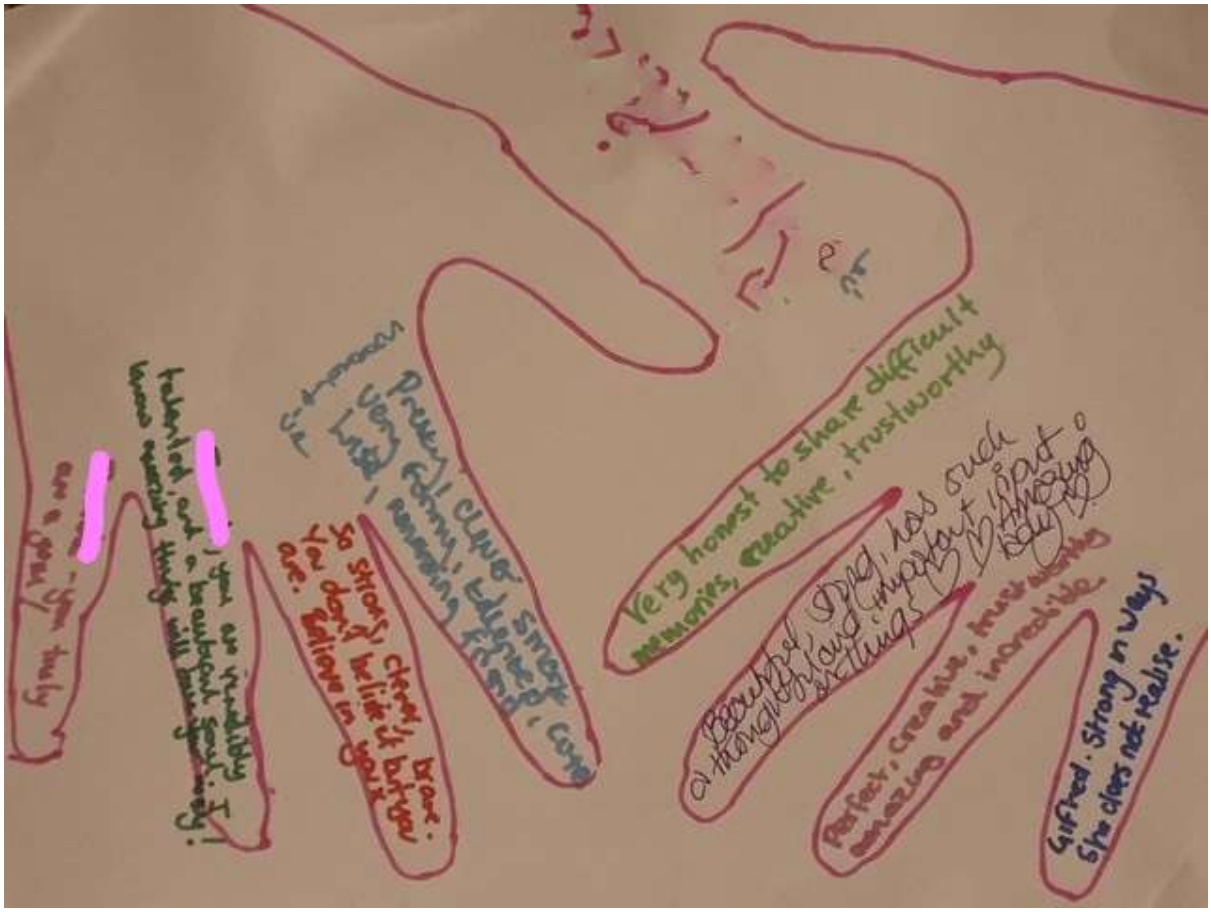
| | | | |
|---|---|---|---|
| | | | |
| ‘14’ | 2 month follow up | | |

**APPENDIX 11: EXAMPLE OF A NEWSLETTER TO SENT TO SERVICE USERS OF THE AGENCY.**

## APPENDIX 12: TREE OF LIFE, APPRECIATION EXERCISE AND ENDINGS




**Tree of Life.** Key: Roots: Where we came from (research questions), Ground: Daily Life, Trunk: Our strengths and skills, Branches: Hopes and dreams, Leaves: Meaningful people or supports in our lives, Fruit: gifts we give and receive.




**Appreciation Exercise**. In the final session, the co-researchers drew around their hands and the other women wrote appreciations of them on the drawing. This was Jade's. The drawings were taken home and were a way to capture the sentiments of the other group members towards the individual.



**Endings.** At the last session, I gave all of the co-researchers a small, engraved wooden star to mark their contribution.


**Endings.** Also, at the last session, Freya gave each of the co-researchers a box picture with their names at the top (obscured to provide confidentiality) and words specially chosen as feedback. This was the one given to Rose.